Kally Cheema LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

[redacted]

[redacted]

9 January 2024

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] **- CEO of North Cumbria Intergrated Care**

CORONER

1 I am Dr Nicholas Shaw - HM Assistant for Cumbria

CORONER'S LEGAL POWERS

2 I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 16 February 2023 I commenced an investigation into the death of Karena WICKINGS. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Death from complications arising from an essential surgical procedure.

3 1a Pulmonary Embolism

1b

1c

II

CIRCUMSTANCES OF THE DEATH

4 Karena Wickings - aged 58 died in her home in Brampton, Cumbria on 5th February 2023. She had been admitted to hospital two months previously for laparoscopic surgery to remove a screening detected colonic cancer. She had a prolonged admission due to multiple postoperative complications requiring further surgeries. Throughout her

admission she was given anticoagulant prophylaxis in the form of enoxaparin. Her clinical condition was improving and it seemed as if the cancer had been fully removed but at the time of discharge her mobility remained significantly restricted. Anticoagulant prophylaxis stopped when she left the hospital and it is unclear if ongoing indication was considered. It is more likely than not that the lack of ongoing prophylaxis led to the formation of thrombosis in her left leg and her death due to pulmonary embolism.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

5 (1) The surgical mortality review conducted after Karena's does not seem to have considered the role that anticoagulation may have played. I understand trust guidelines suggest it continues until 5-7 days or until the patient regains full mobility. I was told many surgeons will extend this to 28 days. Karena was past the 28 day period but still had significant restriction at the time of discharge. A few years ago I heard a very similar case which occurred at a different health trust. The purpose of this report is to suggest that discharge planning might have a prompt to consider possible ongoing anticoagulant prophylaxis in patients who leave the hospital but have not yet regained full mobility.

(2)

(3)

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you and the wider trust have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 6th March 2024. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [NAMES]

8 I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9 9 January 2024

Signature 

Dr Nicholas Shaw HM Assistant Coroner for