REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Lancashire Teaching Hospitals; 2) NHS England
1	CORONER I am Alison Mutch, HM Senior Coroner, for the coroner area of South Manchester
2	CORONER'S LEGAL POWERS 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
3	INVESTIGATION and INQUEST On 9th February 2023 I commenced an investigation into the death of Rhys Lennon Hill. The investigation concluded on the 20th December 2023 and the conclusion was one of **Narrative: Died from a complication of a previous surgical procedure, where the complication was not identified until after his death.** The medical cause of death was **1a) Pulmonary Embolus; 1b) Deep Vein Thrombosis formation in the context of recent Primary Lumbar Discectomy**
4	CIRCUMSTANCES OF THE DEATH Rhys Lennon Hill had spinal surgery at the Royal Preston Hospital. On 30th January 2023 Rhys was offered his Dalteparin. He refused it. On the balance of probabilities that refusal was linked to the time it was offered at and because he was in some discomfort. The refusal of Dalteparin was not escalated to the clinical team and there is no evidence that the risk presented by the omission of the dose of Dalteparin was evaluated by the treating clinicians. Rhys was discharged on 30th January 2023 from the Royal Preston Hospital. The Trust policy required that at discharge a patient and their family members must be provided with verbal and written information about VTE. The Trust policy was not followed. As a consequence, Rhys and his family did not have clear instructions on how to reduce the risk of developing a VTE and the symptoms to look for. This probably increased the risk of Rhys developing a VTE. On 9th February 2023 Rhys collapsed at his home address and attempts to resuscitate him were unsuccessful. A post-mortem examination found

	that he had died from a pulmonary embolus due to a deep vein thrombosis. On the balance of probabilities, the cause of his deep vein thrombosis was the recent surgery he had had undertaken. The risk of him developing a deep vein thrombosis was increased by the Trust discharge policy not being followed and a risk assessment not being undertaken following his refusal of the Dalteparin on the morning of the discharge.
5	<u>CORONER'S CONCERNS</u> 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. – 1. The inquest heard evidence that communication between clinicians and the nursing team on the neurosurgical ward was not effective. The teams appeared to operate in silos and key information about patients did not appear to have been shared between the teams; 2. Documentation (clinical and nursing) was incomplete and did not detail key/important information about Rhys. This included ward round notes containing limited information which meant it was difficult to know what matters had been considered as part of discharge planning and what information was known to the clinicians; 3. THE VTE policy was not fully followed and there was evidence that there was limited understanding by staff of precisely what the trust policy required in relation to reducing the risk at discharge of VTE; 4. Despite a critical medicine being not given to Rhys there appeared to be no clear policy on how that would be escalated to a senior nurse/ treating clinician and how that escalation would be captured in the notes; 5. The evidence was that the system and responsibility between the hospital pharmacy and clinicians for reconciling medications given in the community with those given in the hospital to ensure all necessary medications were given was unclear. As a consequence, Rhys did not receive his ADHD medication; 6. There appeared to be limited understanding amongst the nursing team of when a hospital "passport" system should be instigated for someone who was admitted with a "passport"; 7. The system for deciding when a discharge form the neuro surgical ward was safe was unclear. The evidence appeared to suggest that the Physiotherapy team took responsibility for it if they assessed mobility at a suitable level. It was unclear how that was overseen and fitted with the responsibility of the treating clinician; 8. The VTE policy of the trust is based on the NICE guidance. The inquest identified that there is a difference in approach on the use

	of prophylaxis for a surgical bariatric patient and a neuro surgical patient. Where there is a bariatric patient who is a neuro surgical patient there does not appear to be any clarity on how the challenges should be approached to reduce the risk of VTE as far as possible.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th 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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted] of Ison Harrison Solicitors on behalf of Mr Hill's Family, who may find it useful or of interest. 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	**Alison Mutch** **HM Senior Coroner**  **15.01.2024**