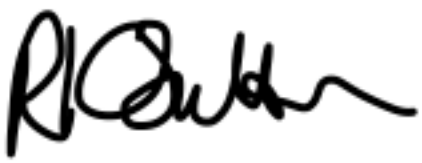
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Emily Kate Harkleroad (died 19 December 2022)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Executive Medical Director of the County Durham and Darlington NHS Foundation Trust** **2. [redacted], Vice President and General Manager, Oracle Health UK**
1	**CORONER** I am Rebecca Sutton, assistant coroner, for the coroner area of County Durham and Darlington.
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 6 January 2023 an Inquest was opened into the death of Emily Kate Harkleroad, aged 31. The investigation concluded at the end of the inquest on 17 January 2024. The medical cause of death was Pulmonary Embolism. The conclusion of the Inquest was a narrative conclusion: *The Deceased death was due to natural causes. However, on a balance of probabilities, Deceased's death would have been preventable had appropriate medical treatment been provided.*
4	**CIRCUMSTANCES OF THE DEATH** On 18 December 2022 the Deceased collapsed when out with a friend. She was taken by ambulance to the University Hospital of North Durham Emergency Department. Despite staff recognising that Pulmonary Embolism was the likely diagnosis, there were failures to provide the Deceased with appropriate and timely treatment for Pulmonary Embolism. Errors and delays in the Deceased's medical treatment resulted in her not receiving the anticoagulant treatment that she needed, and which would, on a balance of probabilities, have prevented her death. The Deceased died as a result of Pulmonary Embolism in the early hours of 19 December 2022 at the University Hospital of North Durham.
5	**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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – I heard evidence that in or around October 2022 a new computer system was introduced into

	the Emergency Department of the University Hospital of North Durham. The provider of the new system is Cerner. I understand that Cerner is now owned by Oracle Corporation. I heard evidence that the previous software in use in the Emergency Department included a "RAG rating" system, which ensured that the acuity of the patients was easily identifiable by looking at a single page on a display screen. I heard evidence that the new Cerner software did not include such a system. I understand that, instead, the Cerner software has symbols next to patient's names that, when clicked on, provide an indication of the level of acuity of the patient, but not a clear indication at first glance. In summary, I was told that the previous RAG rating system was an effective tool in quickly identifying patients requiring urgent oversight by senior clinicians, especially when the Department was under extreme pressure. It is my view that, especially in times of extreme pressure on the Emergency Department, a quick and clear way of identifying the most critically ill patients is an important tool that could prevent future deaths. I was told that concerns about the absence of a RAG rating type system had been raised by a number of clinicians, but that the response, thus far, had been that the new system does not have that functionality.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 1 April 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 [redacted] (Partner of the Deceased) [redacted] (Deceased's GP) County Durham and Darlington NHS Foundation Trust 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	 **5 February 2024**