REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Officer of Princess Alexandra NHS Trust**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 20 April 2023 an investigation was commenced into the death of Ernest Smith, aged 77 years. Ernest Smith died on 10 April 2023. The investigation concluded at the inquest on 26 February 2024. The conclusion of the inquest was narrative: Mr Smith developed left leg haematoma secondary to prophylactic anticoagulation for venous thromboembolism. Mr Smith developed septic infection that did not respond to treatment. With a medical cause of death of 1a Sepsis 1b Hospital Acquired Pneumonia and Infected Haematoma 1c Haematoma Secondary to Anticoagulation, 2 Type II Diabetes Mellitus, Chronic Kidney Disease and Chronic Obstructive Pulmonary Disease
4	CIRCUMSTANCES OF THE DEATH Ernest Smith died at the Princess Alexandra Hospital on 10 April 2023 due to Sepsis due to Hospital Acquired Pneumonia and Infected Haematoma. The Haematoma was secondary to Anticoagulation in a background of Type II Diabetes Mellitus, Chronic Kidney Disease and Chronic Obstructive Pulmonary Disease. Mr Smith was admitted to hospital on 22 February 2023 unwell. Mr Smith received prophylactic anticoagulation to prevent blood clots and was noted to have stripe type bruising on his lower limbs on 10 March and required a medical review that was undertaken on the evening of 12 March and the anticoagulation was stopped on 13th March following the development of a left

	leg haematoma requiring surgical evacuation and debridement. Mr Smith was discharged for rehabilitation on 17 March and readmitted on 23 March with bleeding from the haematoma. Mr Smith was noted to have purulent infection on 30 March and the surgical team awaited advice from Broomfield Hospital. Antibiotics were commenced on 3 April and Mr Smith was septic on 4 April and underwent debridement of his haematoma on 5 April. Mr Smith continued on antibiotic therapy on the advice of microbiology and developed pneumonia, he deteriorated over 9th April and 10 April.
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 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. – a. Medical review requested on 10 March by nurses due to concerns about the acute development of bilateral bruising on Mr Smith's legs. This request was chased by nurses on 11 March and was not conducted until the evening of 12 March. b. A further medical review was conducted in the early hours of 13 March as Mr Smith was in pain and had developed a leg haematoma. c. It took 3 days for consultant review of Mr Smith. On 13 March Mr Smith was reviewed by a consultant from another ward and prophylactic anticoagulation was discontinued. d. Mr Smith was medically reviewed and considered fit for discharge on 30 March. A tissue viability nurse review that day noted an infected leg haematoma and recommended a surgical referral for consideration of washout and debridement. e. Antibiotics for the infected haematoma were not commenced until 3 April. f. Sepsis was highlighted by the Trust surgical team on 3 April and the Sepsis Protocol was not followed. .
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 9 May 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: • Wife of Mr Smith 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	 **14 March 2024** **HM Area Coroner for Essex Sonia Hayes**