Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Frimley Health NHS Foundation Trust** **2 National Institute of Clinical Excellence** **3 NHS England**
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire for the coroner area of Berkshire
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. It is important to note the case of R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION and INQUEST** The family requested me to refer to the deceased as Ellen. I will reflect that in this report. Ellen was 24 at the time of her death. I conducted an inquest into the death of Ellen Mercer which concluded on 10th of April 2024. I recorded a narrative conclusion as follows: Ellen's death was caused by nitrous oxide use and immobility, which led to the development of pulmonary emboli.
4	**CIRCUMSTANCES OF THE DEATH** Ellen Mercer attended Wexham Park Hospital, Slough in Berkshire, arriving by ambulance in the early hours of 9 February 2023. The starting point for her deterioration and hospital attendance was her mental health and her use of nitrous oxide. The cannisters she used had caused injuries to her legs and decreased her mobility. Ellen arrived at Wexham Park Hospital at 00.48. She died there almost exactly 24 hours later, in the emergency department. No formal VTE risk assessment took place. A post mortem examination revealed that her cause of death was : 1a Bilateral Pulmonary Artery Thromboembolus 1b Deep Vein Thrombosis 2 Long term complications of nitrous oxide abuse, including immobility
5	**CORONER'S CONCERNS**

During the course of the investigation my enquiries 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:

1. Patients are unfortunately waiting increasingly longer times in emergency departments – not just in waiting areas, but also after being seen by clinical staff and waiting for admission to a ward or discharge from the hospital. During this time, current policies do not require VTE risk assessment.
2. The policy for this trust suggests that the 24 hour period (during which VTE risk assessment must take place) starts only when a patient is “admitted” to hospital, i.e. when a decision is taken to admit them to a ward – which could be many hours after they have originally attended the emergency department.
3. The policy as currently drafted implies that VTE risk assessment is essentially not relevant for emergency department patients.
4. If current policies require VTE risk assessment to take place within 24 hours, the point at which that 24 hour period starts is not sufficiently clear and does not take long waits in emergency departments into account. I am concerned that policies may need to reflect the current reality on the ground.
5. I suspect that this issue may be a national one.

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 June 21, 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 Ellen’s family.

I have also sent this report to the following recipients, who have an interest in this matter:
1. Royal College of Emergency Medicine.
2. Royal College of Physicians.
3. Chief Executive of Royal Berkshire Hospital NHS Trust.
4. Legal representative for South Central Ambulance Service.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any person who I believe may find it useful or of interest.

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	**Dated: 26/04/2024** **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**