



Ref: [REDACTED]

30 July 2024

Mr David Reid  
HM Senior Coroner  
Worcestershire Coroners Court  
The Civic  
Martin's Way  
Stourport on Severn  
Worcestershire

Sent via email: [REDACTED]

Dear Mr Reid

**Re Regulation 28 Report to Prevent Future Deaths**

Please accept this letter in response to your Regulation 28 Report to Prevent Future Deaths received on the 7<sup>th</sup> June 2024, following the Inquest touching on the death of Mrs Susan Edwards.

In your Regulation 28 report you identified the following matters of concern relating to the Worcestershire Acute Hospitals NHS Trust (WAHT).

- 1) On the 19<sup>th</sup> September 2023 a Venous Thromboembolism Risk Assessment made clear that Mrs. Edwards should be provided with mechanical thromboprophylaxis. This instruction was not entered on Mrs. Edwards' anticoagulation drug card, and Mrs. Edwards was not provided with any form of mechanical thromboprophylaxis between that date and her death 18 days later on 7<sup>th</sup> October 2023. No nurse or reviewing doctor picked up on this omission.

You further stated that although you were satisfied that, in this case, the provision of mechanical thromboprophylaxis would probably not have prevented Mrs. Edwards' death, you were concerned that:

- a) No system appears to be in place at Worcestershire Royal Hospital to ensure that such an instruction is carried out; and
- b) As long as that remains the case, the lives of patients who require thromboprophylaxis during a hospital admission may be put at risk.

Responding to the concerns raised;

1. We have focused on educating our staff in order to provide clear instructions around this area and will implement the following:

- There will be a Lesson of the week around what constitutes both hosiery and mechanical prophylaxis, and it will be reiterated to staff that they must sign the prescription chart to confirm that this prophylaxis is on/in place.
- Anti-coagulation nurses are going to provide some teaching to the junior doctor workforce to ensure their understanding of the practical impact of the different types of prophylaxis.
- Anti-coagulation nurses have also offered to provide teaching to ward nurses.
- Reminder of the above is to be verbalised across all areas via safety huddles.

2. Monitoring:

- Checks of the prescription charts will be included on the matron's audits (to check that the prescription has been signed as in/on)
- Continue to audit via the matron's audit already in place and divisional governance teams will continue their surveillance and escalate accordingly.

3. Long term plan is this will be on the electronic patient medical prescribing / administration system.

I hope that the above addresses your concerns about the quality of our initial review. I have no representations in respect of publication of the Regulation 28 or this response by the Chief Coroner.

I shall be grateful if you could kindly send a copy of my response to anyone to whom you copied your Regulation 28 report.

Yours sincerely

A large black rectangular box redacting the signature of the Chief Executive.

Chief Executive