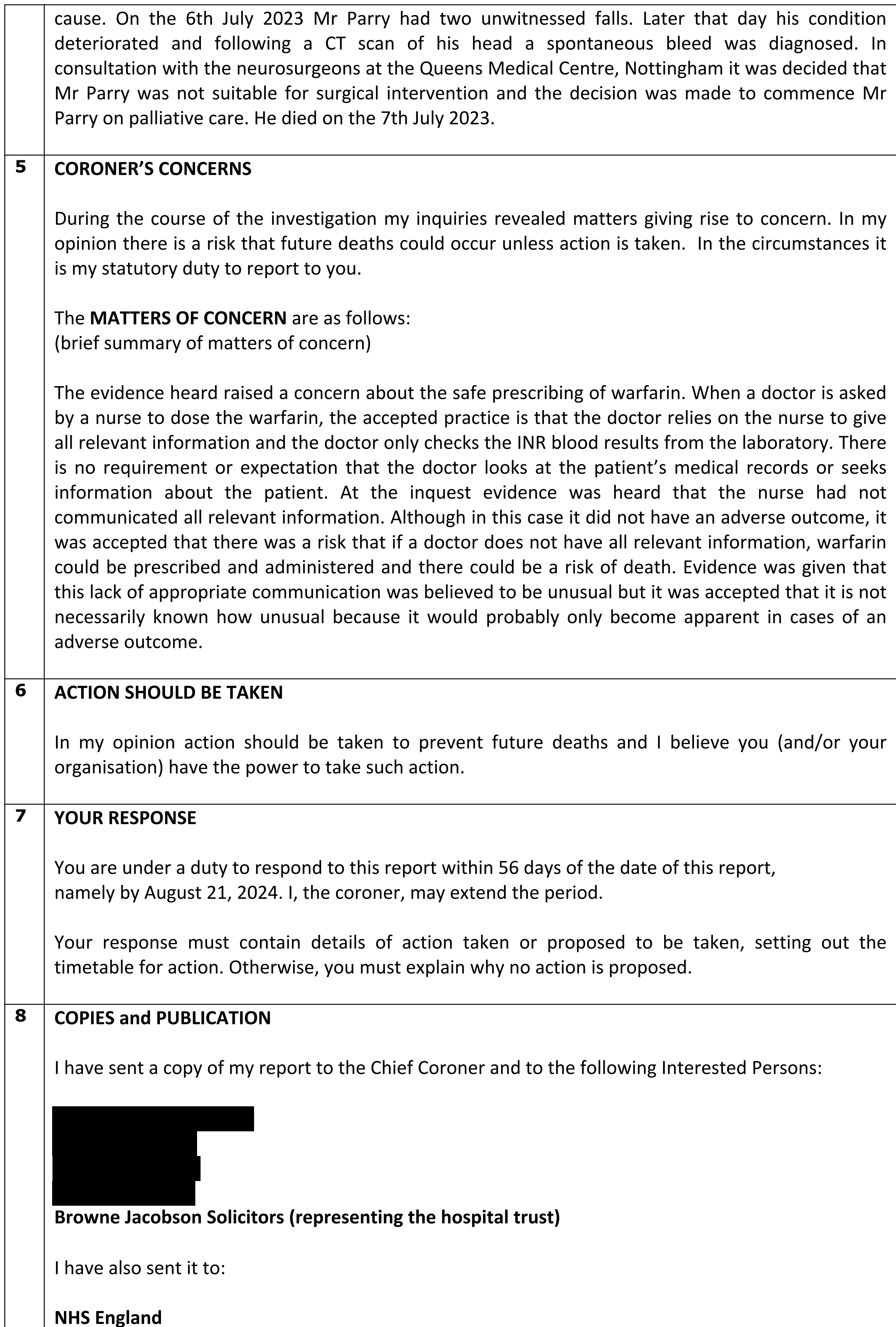
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **University Hospitals of Leicester NHS Trust**
1	**CORONER** I am Professor C E MASON, His Majesty's Senior Coroner for the coroner area of Leicester City and South Leicestershire.
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 16 November 2023 I commenced an investigation into the death of John Kenneth PARRY aged 72. The investigation concluded at the end of the inquest on 26 June 2024. The conclusion of the inquest was that: Following the falls on the 6th July 2023 Mr Parry was commenced on neurological observations. However, they were not carried out in accordance with the hospital trust policy. In addition, the calculations were inaccurate. As a result, no reliance could be placed on the observation recordings. Medical evidence also makes it clear that Mr Parry should have had a CT head scan within one hour of his fall. Had this been carried out, on a balance of probabilities, the intracranial bleed could have been detected sooner and there would have been a chance of reducing the mortality risk and achieving a better outcome. The cause of death was established as: I a Spontaneous Intracerebral Haemorrhage I b I c II Mitral Valve Disease (On Anticoagulation)
4	**CIRCUMSTANCES OF THE DEATH** John Parry was a 72-year-old male who was admitted to the Leicester Royal Infirmary via the Emergency Department on the 4th July 2023. He presented with feeling unwell for six weeks, a headache for one month, weight loss and an increased urinary frequency for a few days prior to admission. He was appropriately investigated but no conclusive diagnosis was made regarding the



cause. On the 6th July 2023 Mr Parry had two unwitnessed falls. Later that day his condition deteriorated and following a CT scan of his head a spontaneous bleed was diagnosed. In consultation with the neurosurgeons at the Queens Medical Centre, Nottingham it was decided that Mr Parry was not suitable for surgical intervention and the decision was made to commence Mr Parry on palliative care. He died on the 7th July 2023.

5 CORONER'S CONCERNS

During the course of the investigation my inquiries 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:
(brief summary of matters of concern)

The evidence heard raised a concern about the safe prescribing of warfarin. When a doctor is asked by a nurse to dose the warfarin, the accepted practice is that the doctor relies on the nurse to give all relevant information and the doctor only checks the INR blood results from the laboratory. There is no requirement or expectation that the doctor looks at the patient's medical records or seeks information about the patient. At the inquest evidence was heard that the nurse had not communicated all relevant information. Although in this case it did not have an adverse outcome, it was accepted that there was a risk that if a doctor does not have all relevant information, warfarin could be prescribed and administered and there could be a risk of death. Evidence was given that this lack of appropriate communication was believed to be unusual but it was accepted that it is not necessarily known how unusual because it would probably only become apparent in cases of an adverse outcome.

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 August 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 the following Interested Persons:

Browne Jacobson Solicitors (representing the hospital trust)

I have also sent it to:

NHS England

	who may find it useful or of interest. 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: 27/06/2024** **Professor C E MASON** **His Majesty's Senior Coroner for Leicester City and South Leicestershire**