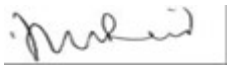
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester WR5 1DD;
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17 October 2023 I commenced an investigation and opened an inquest into the death of Susan Lynne EDWARDS. The investigation concluded at the end of the inquest on 28 May 2024 The conclusion of the inquest was that Mrs. Edwards "*Died as the result of a recognized complication of an accidental fall".*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mrs. Edwards come by her death?", I recorded as follows: "On 7.10.23 Susan Edwards, who had fractured her left neck of femur in a fall in hospital in August 2023, and who had been admitted to Worcestershire Royal Hospital on 10.9.23 and treated for a likely urinary tract infection, suffered a sudden deterioration in her condition. Despite treatment, she declined and died in hospital later the same day. Post mortem examination has established that she died as the result of developing a large pulmonary embolus."
5	**<u>CORONER'S CONCERNS</u>** 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. – 1) On 19 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 October 2023. No nurse or reviewing doctor picked up on this omission.

	Although I was satisfied that, in this case, the provision of mechanical thromboprophylaxis would probably not have prevented Mrs. Edwards' death, I am 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of Worcestershire Acute Hospitals NHS Trust, 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 **30 July 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: (a) [redacted], Mrs. Edwards' daughter. 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	**4 June 2024**  **David REID** **HM Senior Coroner for Worcestershire**