**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO:<br><br>1)NHS England 2) East Cheshire NHS Trust |
| 1 | CORONER<br><br>I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester |
| 2 | CORONER'S LEGAL POWERS<br><br>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<br><br>On 8th January 2024 I commenced an investigation into the death of David Nicholas ALMOND. The investigation concluded on the 8th July 2024 and the conclusion was one of Narrative: **Died from the complications of thrombophilia when he had not been placed on lifelong anticoagulants when he should have been. The medical cause of death was 1a) Massive pulmonary embolism 1b) Thrombophilia.** |
| 4 | CIRCUMSTANCES OF THE DEATH<br><br>David Nicholas Almond had a family history of deep vein thrombosis. He was diagnosed with thrombophilia in 2013. That information was in his GP records. On 7th September 2022 he was diagnosed with a deep vein thrombosis at Macclesfield District General Hospital and started on anticoagulant medication and referred to the deep vein thrombosis clinic. The notes indicate that thrombophilia and a family history of deep vein thrombosis were mentioned. On 21st September 2022 he had a telephone appointment with the deep vein thrombosis clinic. His family history and diagnosis of thrombophilia was not explored fully and he was not placed on lifetime anticoagulation. He should have been. On 25th September 2023 he complained of breathlessness on exertion. He was seen by an advanced nursing practitioner at his GP surgery. The possible risk of an embolism was not recognised and he was sent for an x ray which would not diagnose a pulmonary embolism. The x ray was clear. He was not seen again although the x ray excluded other potential causes of his breathlessness. On 3rd January 2024 he collapsed at his home address and was taken to Stepping Hill Hospital where a massive |

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| | pulmonary embolism was found. He deteriorated and died at Stepping Hill Hospital on 5th January 2024. |
| 5 | CORONER'S CONCERNS<br><br>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.<br><br>The MATTERS OF CONCERN are as follows. –<br><br>1. The inquest heard evidence that Macclesfield Hospital was part of East Cheshire NHS Trust and served a wide area a significant part of the area served was outside the footprint of the trust for example the High Peak in Derbyshire. The inquest was told that trust doctors were able to access GP records for patient's registered with GPs in East Cheshire but not patients registered outside this area. The inquest was told there were discussions about how to try to resolve this but no firm steps or progress on this by the Trust.<br>As a consequence doctors at the hospital were limited in understanding a patient's history and crucial information was not always fully recognised/available.<br><br>2. The inquest was told that this inability to access information in GP records was a problem across the NHS due to differing IT systems and caused difficulties in providing effective and timely care to patients.<br><br>3. The inquest heard evidence that in September 2023 when he went to his GP practice he did not see a doctor. It was not recognised by the practitioner who saw him that there may need to be a follow-up appointment or a recommendation that he return to see a doctor should the x ray be negative given his history and presentation. |
| 6 | ACTION SHOULD BE TAKEN<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | YOUR RESPONSE<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th September 2024. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain |

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| | why no action is proposed. |
| 8 | COPIES and PUBLICATION<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted] on behalf of the family, GTD Healthcare, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Alison Mutch**<br>**HM Senior Coroner**<br><br>  <br><br>**17/07/2024** |