REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive of County Durham and Darlington NHS Foundation Trust.**
1	**CORONER** I am Janine Richards, assistant coroner, for the coroner area of Durham and Darlington
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.
	INVESTIGATION and INQUEST On the 22nd of March 2023 an investigation was commenced into the death of Janet Rice. The investigation concluded at the end of the inquest on the 23rd of July 2024 . I gave a narrative conclusion as follows :- Janet Rice, aged 65 years, died at Darlington Memorial Hospital on the 19th of March 2023 as a result of Pulmonary and Cerebral Embolism, subsequent to surgery to repair a hip fracture which she had sustained in an accidental fall on the 19th of February 2023, and in the absence of anti coagulant treatment. The medical cause of death was :- 1a) Pulmonary and Cerebral Embolism 1b) Right sided Neck of Femur Fracture

4	**CIRCUMSTANCES OF THE DEATH** Janet Rice, 65 years, died in hospital on the 19.3.23 as a result of pulmonary and cerebral embolism, subsequent to surgery to repair a hip fracture which she had sustained in an accidental fall on the 19.2.24. In the aftermath of her surgery the deceased did not receive prophylactic anti coagulant medication consistently. On one occasion this was missed due to a transfer between hospitals. On five further occasions this was omitted as a result of the deceased declining such, at a time when she was suffering an acute delirium, and described variously as confused, paranoid and agitated. No assessment of her capacity to decline the medication was carried out, and therefore no best interests decision was made, nor any further consideration given as to how the known high risk of blood clots subsequent to the surgery could be best or alternatively managed. There was no escalation to an Advanced Nurse Practitioner or Doctor to consider these issues further. It is unlikely that the deceased had capacity to decline treatment but impossible to know what the result of any best interests decision would have been, and whether further or alternative actions would have prevented her death. It is accepted that the omission of anti coagulant contributed more than minimally to the development of the Pulmonary Embolism and thus to death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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) The final version of the patient safety investigation report carried out by the Trust was only received on the first day of the Inquest, some 16 months after the death. The concerns raised in this Inquest have been well known to the Trust for a considerable period of time and the concern is that lessons cannot be learned in a timely fashion if patient safety investigations are so significantly delayed. (2) The patient safety investigation report is not a comprehensive and robust review of the omissions in provision of anti coagulant and does not consider or address the omission to administer anti coagulant because the deceased was transferred between hospitals, nor does it detail all of the incidents of missed anti coagulant, some of which only became apparent upon receipt of the independent expert report. It's remit and action plan are limited to the community hospital only, and do not consider or address the further instances of omission to administer anti coagulant in the acute hospital setting, where there was a continued failure to carry out a capacity assessment and any subsequent best interests decision making process, failure to escalate these issues, and/or to consider any alternative treatment to reduce the high risk of DVT/PE. (3) Although evidence was heard in relation to the provision of further training in relation to the issues of capacity and best interests decision making, to address the concerns identified in this investigation this was limited to the community hospital setting, when it is known that the issues continued in the acute hospital setting.
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 17.09.24 . 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; the family of the deceased and the Tees, Esk and Wear Valley Foundation Trust (TEWV). 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	23.07.24