REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: National Institute for Health and Care Excellence
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 28th May 2024 I commenced an investigation into the death of Audrey Margaret LAMBERT .The investigation concluded on the 14th October 2024 and the conclusion was one of narrative: **Died from the complications of a deep vein thrombosis following an accidental fall and necessary surgery. The medical cause of death was 1a) Pulmonary Thromboembolism 1b) Deep Vein Thrombosis II) Sub trochanteric fracture right proximal femur (operated on)**
4	CIRCUMSTANCES OF THE DEATH Audrey Margaret Lambert had an accidental fall at her home address on 25th March 2024. She was admitted to Stepping Hill Hospital and found to have a fracture of the right proximal femur. She was operated on. Post operatively she was prescribed 28 days course of heparin. Subsequently she was cared for at Brinnington Hall. Her mobility was significantly reduced and she required a hoist and the assistance of two to mobilise. On 28th May she was found unresponsive in bed. A post mortem found she had died from pulmonary thromboembolism due to a deep vein thrombosis.
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. – The inquest heard evidence that prior to the fall and fracture Mrs Lambert

	had been mobile. Following the operation her mobility was very limited. She was prescribed the standard heparin treatment post operatively. The inquest was told that it was recognised in her case that she had become very immobile since her fall. However the inquest was told that there was no national guidance that would assist clinicians in primary care in assessing whether they should consider prolonging the course of anti-coagulation prescribed in secondary care to reduce the ongoing risk of elderly immobile patients such as Mrs Lambert developing a fatal DVT in the community.
6	ACTION SHOULD BE TAKEN 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 You are under a duty to respond to this report within 56 days of the date of this report, namely by **31st December 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 namely [redacted] and [redacted] on behalf of the family, who may find it useful or of interest. 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	**Alison Mutch** **HM Senior Coroner**  **05/11/2024**