H M Area Coroner for Gloucestershire
Mr Roland Wooderson

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Department of Health & Social Care**
1	**CORONER** I am Roland Wooderson Area Coroner for the coroner area of Gloucestershire
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 23 April 2024 I commenced an investigation into the death of Maria Simpson. The investigation concluded at the end of the inquest on 8 January 2025. The conclusion of the inquest was by way of narrative conclusion recording the facts set out in box 4. below.
4	**CIRCUMSTANCES OF THE DEATH** On 4 August 2022 Maria attended her GP advising that she was pregnant and that she had been prescribed heparin during her previous pregnancy. She asked whether this was necessary again. Her GP made a referral for advice to a hospital. The GP did not mention in the referral that there had been historic instances of recurrent pulmonary embolisms, albeit this did not contribute to Maria's death. The referral was returned to the GP by an administration officer at the hospital without a clinician seeing the same. The evidence was that this probably made more than a minimal contribution to Maria's death as a clinician would have advised immediate administration of heparin. The referral was then dealt with by another hospital. The GP was advised by the hospital to refer Maria to the obstetrics service. Thromboprophylaxis was recommended once pregnancy was confirmed. Evidence given was that the clinician that responded to the GP's referral was not aware of the risk of bleeding associated with heparin as known at that time. With that knowledge, that clinician would have recommended the immediate administration of heparin without waiting for clinical confirmation of pregnancy. The GP endeavoured to contact the obstetric service via the community midwife team. The electronic request was not accessed, due to staff leave, until after Maria's death on 24 August 2022.

Gloucestershire Coroner's Court, Corinium Avenue, Barnwood, Gloucester, GL4 3DJ
Tel [redacted] | [redacted]

	The cause of death was recorded as massive recurrent pulmonary thromboembolism and deep vein thrombosis.
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. – Evidence was given in the inquest to the effect that medical General Practitioners have no uniform national case management system for electronic storage of patients' records. This leads to a situation whereby, upon transfer of patient records from one practice to another, the receiving practice is obliged to input all the records afresh if the practices operate different systems. This can lead to delay in the compilation of records. Further, it appears that a case management system is unable to store electronically all historic documents such as referral letters from one clinician to another, due to electronic capacity issues. This leads to a situation where some patient information is stored electronically and some in paper form making it difficult for the GP to note quickly all relevant patient information.
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 6 March 2025. 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. (Through legal representatives) The family of Maria Simpson, Gloucestershire Hospitals NHS Foundation Trust, University Hospitals Bristol & Weston Foundation Trust, [redacted]. 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	**9 January 2025** **Area Coroner Roland Wooderson**