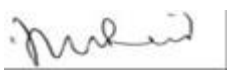
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester WR5 1DD;
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** 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 3 April 2024 I commenced an investigation and opened an inquest into the death of Vauna LEEMING. The investigation concluded at the end of the inquest on 15 January 2025. The conclusion of the inquest was that Mrs. Leeming *"died from natural causes, to which a recent fractured neck of femur and surgical repair thereof contributed"*.
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mrs. Leeming come by her death?", I recorded as follows: *"On 6.2.24 Vauna Leeming was admitted to Worcestershire Royal Hospital after suffering an accidental fall at home, and was found to have sustained a fractured right neck of femur. She underwent surgery to repair the fracture on 8.2.24, from which she initially made a satisfactory recovery. However, on 23.3.24 her condition deteriorated, and she tested positive for Covid-19. She went on to suffer a pulmonary embolism and, despite treatment, declined and died in hospital on 25.3.24."*
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 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) Following Mrs. Leeming's surgery on 8.2.24, measures were put in place to prevent the formation of a deep vein thrombosis and/or pulmonary embolism. Those measures were prescriptions for anticoagulation medication (Enoxaparin) and for compression stockings. The inquest heard evidence that over the 46 days between the surgery and Mrs. Leeming's death: (a) on 2 days (10 and 13.2.24) no documentation was completed by nurses to show whether Enoxaparin had in fact been administered; and

	(b) on a total of 15 days (including 5 consecutive days in one week) no documentation was completed by nurses to show whether compression stockings had been fitted and were being worn; 2) It was of particular concern that for 5 consecutive days, no nurse had noticed or raised with a senior colleague that the prescription charts had not been completed to show that compression stockings had been fitted. This suggests either that there is little understanding of a nurse's professional duty to report such omissions, or that the practice of not checking and completing such important documentation is commonplace; 3) The inquest heard evidence that whilst in its induction to new nurse employees, the Trust emphasises the importance of completing documentation, it is still heavily reliant on agency nurses, for whom it cannot be expected to provide such an induction; 4) I am concerned that the evidence in this case highlights that there is still insufficient awareness among employed and agency nurses at the Trust's hospitals of their professional duty: (a) to complete important documentation such as prescription charts; and (b) to report any omissions in the completion of such documentation to a senior colleague.
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 **14 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: (a) [redacted] (Mrs. Leeming's husband and next of kin); (b) [redacted], National Medical Director, NHS England. 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	**17 January 2025**  **David REID** **HM Senior Coroner for Worcestershire**