ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. President of the Royal College of General Practitioners,** [redacted]
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 17th January 2025, I commenced an investigation into the death of Linda Janet Sharp, aged 70 years. The investigation concluded at the end of the inquest on 18th August 2025. The narrative conclusion of the inquest was:- **Linda Janet Sharp first had symptoms of thromboembolic disease at the time of consultation on the 17th October 2023. She had further presentations to healthcare professionals from that date until the 20th November 2023, all which would have been consistent with thromboembolic disease. Had she been referred to hospital after any of these consultations, a diagnosis of pulmonary embolism would have been considered and she would have received empirical therapeutic anticoagulation therapy with a low molecular-weight- heparin preparation pending definitive tests to confirm or refute the diagnosis. Had such a management plan been instituted, she would not have died on the 21st November 2023**
4	**CIRCUMSTANCES OF THE DEATH** Linda Janet Sharp had significant comorbidities in the form of hypertension, type 2 diabetes mellitus, hypothyroidism, stable angina, left bundle branch block, anaphylactic reaction secondary to penicillin, osteoporosis, gastritis and duodenitis. She also had generalised anxiety and was an ex-cigarette smoker. She attended her General Practitioner on the 17th October 2023 complaining of swelling in her right leg. The WELL's score, which is a risk stratification tool for thromboembolic disease was applied without further testing, that might have included a D Dimer test or Doppler ultrasound study of the calf vessels, and she was reassured and given safety netting advice. On the 2nd November 2023, she was attended by paramedics because of shortness of breath and taken to Scarborough General Hospital for further assessment. Tests for thromboembolic disease were not performed and empirical anticoagulation was not prescribed. She was discharged later that day. On the 6th November 2023, she attended the Emergency Department at Leicester Royal Infirmary due to an allergic reaction, possibly arising from amlodipine therapy. On the 15th November 2023, she was seen by an advanced nurse practitioner at her GP surgery where it was assumed

	her moderately low oxygen saturation was due to chronic pulmonary obstructive disease, but no confirmatory tests were carried out. On the 16th November 2023, she was attended by the ambulance service and was noted to have initial low oxygen saturation levels which rose to normal limits after a second set of observations had been carried out. She was not conveyed to hospital on that occasion. A further attendance by paramedics occurred on the 19th November 2023. I had accepted evidence from the attending paramedic that if he had known about the previous attendance on the 16th November 2023, he would have conveyed Linda to hospital. Mrs Sharp was seen again in her GP surgery on the 20th November 2023 complaining of breathlessness and haemoptysis. Various investigations were commissioned, but pulmonary embolism which can be associated with haemoptysis was not considered in any differential diagnoses that was formulated. Linda Sharp had a cardiac arrest at her home address around 23:30 hours on the 20th November 2023, but despite the provision of advanced life support by paramedics, who attended, she could not be resuscitated and died at 00:31 hours on the 21st November 2023. I have accepted expert evidence that a deep vein thrombosis could have been diagnosed from the 17th October 2023 onwards and that her various presentations in general practice and to the ambulance service were likely to have been underpinned by episodes of thromboembolism. I have also accepted the WELL's score algorithm employed alone, does not exclude a thromboembolism and needs to be supplemented by other tests. If at any point between the 17th October 2023 and the 20th November 2023, when Linda Sharp was associated with healthcare professionals, she had been taken to hospital, on balance, thromboembolic disease would have been considered and steps taken to confirm or refute such a diagnosis. The suspicion of the diagnosis would have resulted in the administration of a therapeutic dose of a low molecular-weight- heparin preparation, which on balance, would have prevented further thrombus formation within six hours of administration, and with this, on the balance of probabilities, the massive pulmonary embolism that occurred before midnight on the 20th November 2023 and her subsequent death on the 21st November 2023 would have been avoided. Treatment would have proceeded before confirmatory tests been performed according to standard protocol.
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. – Expert evidence was heard which stated that it is fundamentally flawed to conflate a low Wells score with there being no possibility of a deep vein thrombosis (DVT) and/or a pulmonary embolus (PE). A Wells score on its own does not exclude a a DVT or PE.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action, possibly by making your membership and other clinicians aware of this.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th November 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 Yorkshire Ambulance Service; [redacted] Scarborough General Hospital; [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	[redacted] **15th September 2025**