



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 Chief Executive Officer, West Suffolk Hospital, Bury Saint Edmunds, Suffolk
1	CORONER I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 16 April 2024 I commenced an investigation into the death of Pamela Christine BRAND aged 73. The investigation concluded at the end of the inquest on 19 February 2025. The conclusion of the inquest was that: Narrative Conclusion - Accidental death contributed to by frailty and underlying medical illness. The medical cause of death was confirmed as: 1a Pulmonary Embolism 1b Deep Venous Thrombosis 1c Recent Fall with Left Hip Fracture (operated)
4	CIRCUMSTANCES OF THE DEATH Pamela Christine BRAND suffered a fall at her residence on the 19 th March 2024. She was found collapsed at the bottom of a set of stairs by her family. Ambulance attended and Mrs. BRAND was transported to hospital. Following assessment, she was diagnosed as having sustained a closed fracture of her left neck of femur. She underwent surgery the following day for a left hip hemiarthroplasty. The procedure was uneventful with no complications reported. Mrs BRAND's previous medical history included a history of blindness in her left eye and reduced function in her right eye. She been diagnosed with breast cancer for which she was receiving ongoing treatment. Mrs. BRAND also suffered with migraines, hypotension, a hernia and Charles Bonnet Syndrome. The latter resulted in Mrs. BRAND suffering from visual hallucinations due to the brain's adjustment to significant vision loss and had significantly impacted on Mrs. BRAND's wellbeing, particularly in the two years leading up to her death, manifesting itself on occasions in confusion. It is likely that this made a material contribution to her suffering a fall on the 19 th March 2024. Mrs. BRAND also suffered from varicose veins which increased her risk of suffering from deep vein thrombosis (DVT). The cumulative effect of Mrs. BRAND's conditions meant that she had become more frail in the 2 years leading to her death. As part of the care and treatment of Mrs. BRAND, she was assessed as being at high risk for the development of DVT and administered an Extended Venous Thromboembolism (VTE) prophylaxis both prior to surgery and then throughout the remainder of her



	admission. Physiotherapy and mobilisation were also attempted on a post-surgery rehabilitation basis as well as to mitigate the DVT risk, although this was impacted on by both the availability of occupational therapists and Mrs. BRAND's medical condition; the latter including her suffering from a degree of postural hypotension and episodes of confusion which was attributed to a combination of pain (which was being actively managed) and her Charles Bonnet Syndrome. On the 2nd April 2024 Ms. BRAND seemed well in the morning. That evening around 22.00 hours, Mrs. BRAND was assisted to the lavatory by a member of hospital staff. Upon sitting down Mrs. BRAND appeared to be faint and then collapsed suffering a cardiac arrest. Attempts to resuscitate Mrs. BRAND were unsuccessful and she was sadly declared deceased a short time later. A post-mortem examination of Mrs. BRAND's body established the medical cause of death to have been due to a Pulmonary Embolism caused by Deep Vein Thrombosis as a result of a Recent Fall with Left Hip Fracture (Operated on).
5	CORONER'S CONCERNS During the course of the investigation my inquiries 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: (brief summary of matters of concern) During the course of the Inquest evidence received by the Court indicated that the hospital records for Mrs. BRAND lacked key detail relating to observations undertaken and the rationale for clinical decision making. This impacted on the Inquest's ability to build a complete picture concerning Mrs. BRAND's presentation, care and treatment during her last admission to hospital. Although not identified as having made a contribution to Mrs. BRAND's death, I am concerned that such poor record keeping may adversely impact on the care and treatment provided to other patients in the future if not addressed.
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 August 14th, 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: Family of Pamela Christine BRAND 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	Dated: 18/06/2025  Darren STEWART OBE HM Area Coroner for Suffolk