Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **The Chief Executive- Sherwood Forest Hospitals NHS Foundation Trust (The Trust)**
2. **……**
3. **……**

1 CORONER

I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire

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 Twelfth December 2019 I commenced an investigation into the death of Marian DAY aged 73.

The investigation concluded at the end of the inquest on the 14th August 2020.

The conclusion of the Inquest was a Narrative as follows:

Marian Day died from a massive intra- abdominal haemorrhage, secondary to a vascular malformation of the spleen. This was not detected in life.
Warfarin, an anticoagulant, given to treat her Atrial Fibrillation was continued in hospital when it should have been omitted, as bleeding was suspected. This prescription error has, on a balance of probability, made a contribution to the haemorrhage.

4 CIRCUMSTANCES OF THE DEATH

Mrs Marian Day died at Kings Mill Hospital, Nottinghamshire on the 18th November 2019, following an admission on the 13th November 2019.

An initial plan was made in the early hours of the 14th November 2019 to withhold the Warfarin as she had low blood pressure and a likely diagnosis of a gastrointestinal bleed. Later on the 14th Mrs Day moved from the assessment unit to the ward, and despite the Warfarin dose being crossed off on the prescription chart, Warfarin was given that evening.

Mrs Day did not have a Consultant review on the ward until the morning of the 16th November, and there was no further recorded discussion of the plan for anticoagulant management. A further dose of Warfarin was given on the evening of the 15th November, when it should have been omitted.

There was no written 'Gastro Intestinal haemorrhage protocol' document placed in the medical records as would be expected, to help prompt review of the anticoagulant management in this situation, as per hospital guidance.

Mrs Day had a sudden collapse on the ward in the early hours of the 18th November. She had a massive bleed into her abdomen at this time, from which she did not recover.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

Whilst there has been a detailed Serious Incident review of the circumstances of Mrs Day's death conducted by the Trust, it remains unclear as to how and why these prescription errors occurred.

It is my view that a similar prescription error could occur again, as there remains a number of different charts and documents that allow for muddled prescribing of, or omission of, anticoagulants, when there are complex medical conditions and concern re likely bleeding.

Whilst the development of an electronic prescribing system may increase the probability of more clarity in prescription of anticoagulants, this is not in place currently. In addition, this alone in my view will not ensure oversight of anticoagulant management, unless other measures are taken to ensure senior review of patients, and a clear prescription plan recorded for all staff to follow.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and 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 20 November 2020. 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:

- The family

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

Elizabeth Didcock, Assistant Coroner Nottinghamshire

Dated: 25 September 2020