REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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THIS REPORT IS BEING SENT TO:

1. **Chief Executive, Nottingham University Hospitals NHS Trust**
2. **Family of Mrs Phyllis Kerry**
3. **[REDACTED] Head of Legal Services, Nottingham University Hospitals NHS Trust**
4. **Chief Coroner**

1 CORONER

I am Mrs Heidi Connor, 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 11 July 2014, I commenced an investigation into the death of Phyllis Kerry, DoB 8 June 1935. The investigation concluded at the end of the inquest on 22 October 2014. The conclusion of the inquest was that the cause of death was :

1a Primary intracerebral haemorrhage
1b Warfarin Treatment
1c Metallic aortic valve and aortic root replacement – ascending aortic aneurysm
2 Hypertension

I recorded a narrative conclusion as follows :

Phyllis Kerry died after suffering a stroke, which was complicated by the Warfarin medication she was on.

4 CIRCUMSTANCES OF THE DEATH

Mrs Kerry had a history of heart valve replacement and aortic aneurysm, and was on long-term Warfarin. She was admitted to the ED at Queen's Medical Centre at 1555 hrs on 28th January 2104, with symptoms suggestive of stroke. She was taken for a CT scan at 1733 hrs. The scan showed a bleed consistent with haemorrhagic stroke.

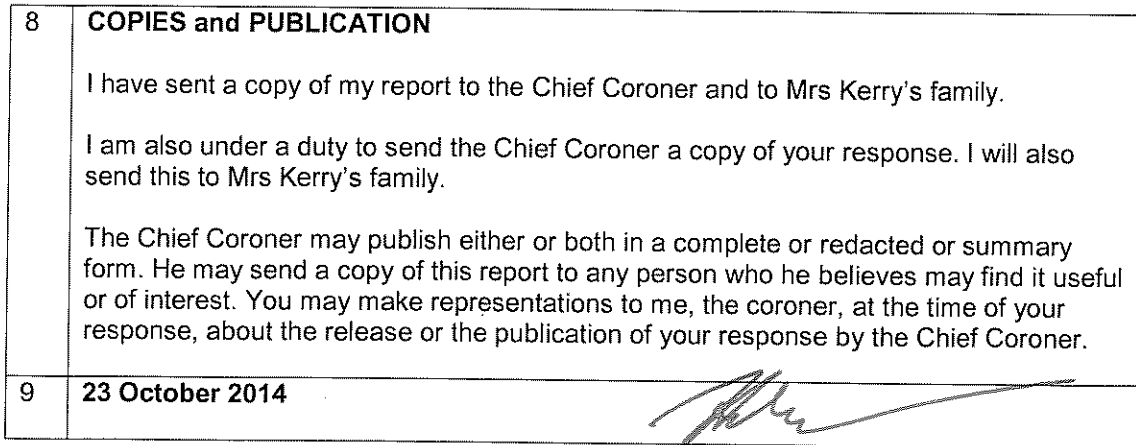
The ED consultant liaised with neurosurgery and haematology colleagues. Neurosurgery advice was that nothing could be done surgically, but that the effects of the Warfarin should be reversed, and they should be contacted again if her condition deteriorated.

The haematology registrar advised giving Mrs Kerry Vitamin K to reverse the Warfarin. He did not recommend giving Octaplex. He did not discuss the case with his seniors or with neurosurgery colleagues. It was accepted in evidence that Octaplex should have been given, to reduce the effects of the Warfarin more quickly.

Mrs Kerry deteriorated, with dropping GCS, and further CT scanning showed that her bleed had increased significantly. After consultation with neurosurgery colleagues, and discussion with her family, a DNAR order was put in place and Mrs Kerry died – her death being confirmed in the early hours of 31st January 2014.

The haematology registrar gave evidence that he carried out research of his own on 28

	January, using Electronic Medicines Compendium, and came to the conclusion that, because of a risk of clotting, it would be better for Mrs Kerry to be given Vitamin K instead of Octaplex. I took evidence from a consultant physician, who said that NICE and RCP guidelines state that both Vitamin K and Octaplex should be given in cases of intracerebral haemorrhage in patients anti-coagulated with Warfarin or similar drugs. The haematology registrar was not aware of these guidelines, and the consultant physician told us that there are no current trust guidelines which cover this – draft guidelines have been withdrawn but not replaced. I also heard that [redacted] a consultant haematologist not involved with this patient, has reviewed the case and advised all haematology and neurosurgery ST doctors that the responsibility for a decision for immediate reversal of Warfarin in patients with CNS bleeds lies with neurosurgery. [redacted] gave evidence that he does not consider this practice has been adopted - that it is simply [redacted] suggestion – and he does not agree that neurosurgery advice is always necessary in cases like this. It is clear that there would need to be involvement from several specialties in relation to prescribing Octaplex in particular. Crucially, however, I could not be clear, from the evidence I heard, which specialty would ultimately be responsible for deciding when immediate reversal is called for. It was also clear that there was no guideline or protocol in place which the haematology registrar could have consulted.
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) Which specialty takes responsibility for deciding when immediate reversal is needed? (2) The absence of clear guidelines for dealing with patients presenting with intra-cerebral bleeds whilst on Warfarin or similar medication. (3)The communication of relevant guidelines to relevant staff. While none of the witnesses I heard from were aware of any relevant guidelines, it is possible that these may in fact already be in existence. Similarly, it may be that draft guidelines are being reviewed. However it was not clear from the evidence when / if these would be finalised. If there are existing guidelines, it would concern me greatly that the witnesses I heard from were unaware of these, and I take the view that communication of guidelines is as important as the guidelines themselves.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 19 December 2014. 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 Mrs Kerry's family. I am also under a duty to send the Chief Coroner a copy of your response. I will also send this to Mrs Kerry's family. 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	**23 October 2014**