IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Doris Mary Ridgwell
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • Mr Daniel Elkeles, Chief Executive, Epsom & St Helier University Hospitals NHS Trust, St Helier Hospital, Wrythe Lane, Carshalton, Surrey SM5 1AA (email: Daniel.elkeles@esth.nhs.uk) • [redacted], Chief Inspector of Hospitals, Care Quality Commission
1	**CORONER** Ms Anna Loxton, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Doris Mary Ridgwell** was opened on 15th March 2017. It was resumed on 19th March 2018 and adjourned until 15th May 2018 when it concluded. I found the medical cause of death to be: 1a. Large Subdural Haematoma and Intraventricular Bleed 1b. Warfarin Therapy II. Community Acquired Pneumonia I determined that Mrs Ridgwell died as a consequence of over-anticoagulation which caused a large subdural haematoma and intraventricular bleed to which she succumbed.
4	**CIRCUMSTANCES OF THE DEATH**

	Mrs Ridgwell was admitted to Epsom General Hospital on 25th February 2017 with a 5 day history of knee swelling and pain. Blood tests were ordered, including INR levels. Her INR level was found to be 8.1 but these results were not successfully telephoned through to the ward or noted by the Healthcare Professionals who managed Mrs Ridgwell's care and she was discharged from the Hospital without any action to counter the high INR. She was admitted to Epsom General Hospital again on 3rd March 2017, having suffered a large subdural haematoma and intraventricular bleed which was not suitable for active treatment. Her INR level on this occasion was 15. The over-anticoagulation was an important causative factor in her bleeds and therefore it is highly likely this contributed to her death.
5	**CORONER'S CONCERNS** Mrs Ridgwell attended Epsom General Hospital on 25th February 2017 with knee pain and swelling. Whilst she did not display symptoms of a high INR, the blood tests ordered by her treating Doctor included her INR level as she was receiving Warfarin therapy. Her INR level was found to be 8.1 which is an abnormally high level requiring attention. Having been noted as abnormally high, the Biomedical Scientist in the Haemotology Department attempted to telephone the result through to Epsom Hospital Emergency Department, in line with the Trust's Standard Operating Procedure. They advised him that Mrs Ridgwell had been transferred to the Ambulatory Care Unit ("ACU"), awaiting discharge. Two attempts were made to telephone the result through to the ACU but there was no reply. The results were then made available on the Clinical Manager system and no further attempt was made to inform the ACU of this result. The Doctor who had requested the blood tests did not note the high INR level on the Clinical Manager system and stated this may be because this result was released onto the system after the other blood tests requested had been made available and checked, and he overlooked reviewing this result as his working diagnosis for Mrs Ridgwell did not include a high INR. Mrs Ridgwell was discharged home to her daughter's address and no Healthcare professionals followed up her high INR. Her over-anticoagulation was only noted and treated on 3rd March 2017, when she was readmitted to Epsom Hospital with a large subdural haematoma and intraventricular bleeds which were not suitable for active treatment, and further blood tests revealed her INR level was 15. She deteriorated until her death on the morning of 4th March 2017.

	The **MATTERS OF CONCERN** are: - The Trust's Standard Operating Procedure for Telephoning of Coagulation Results is not sufficiently clear regarding what action should be taken by staff in the Blood Sciences Department to ensure abnormal coagulation results are made known to the treating Healthcare professionals; - A new Standard Operating Procedure has been prepared, but having had sight of this, I do not believe this clearly outlines for Laboratory staff the steps to be taken in telephoning through abnormal Coagulation Results; - Abnormal results are not authorised onto the Clinical Manager system to be viewed by Healthcare professionals by Laboratory staff until they have telephoned the results through to the ward, which can potentially cause a delay in these being available on the system; - The Discharge summaries provided to GPs following discharge from Hospital do not include blood tests results, meaning a potential safeguard to check these results is missed; Consideration should be given to whether any steps can be taken to address the above concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. See names in paragraph 1 above 2. [redacted] and [redacted] 3. The Chief Coroner

	In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: **ANNA LOXTON** **DATED this 15th day of May 2018**