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. Chief Executive of East Kent University Hospitals NHS Trust**
1	**CORONER** I am Sonia Hayes assistant coroner for the coroner area of North East Kent
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** An investigation was commenced into the death of KEITH RUPERT DIMOND. The investigation concluded at the end of the inquest on 22 August 2022. The conclusion of the inquest was Natural Causes. The medical cause of death was 1a Haemorrhage, Pulmonary Thromboembolism & Infarction 1b Iliac Artery Aneurysm Rupture, Post Ileostomy Reversal & Atrial Fibrillation (Anticoagulated) II Peripheral Vascular Disease, Colitis, Polymyalgia Rheumatica.
4	**CIRCUMSTANCES OF THE DEATH** Keith Dimond died on 24 November 2021 at Queen Elizabeth Queen Mother Hospital of Haemorrhage, Pulmonary Thromboembolism and Infarction due to Iliac Artery Aneurysm Rupture, Post Ileostomy Reversal and Atrial Fibrillation (Anticoagulated) in a background of Peripheral Vascular Disease, Colitis and Polymyalgia Rheumatica. Mr Dimond developed new onset atrial fibrillation during a successful ileostomy reversal on 11 October 2021, commenced on anticoagulation and discharged home 19 October 2021. Mr Dimond was readmitted on 22 October 2021 with an abdominal bleed. Mr Dimond developed multiple bilateral pulmonary thromboembolism and advice was sought from haematology. Mr Dimond was diagnosed with an Abdominal Aortic Aneurysm and Iliac Artery Aneurysm in August 2019. Mr Dimond was treated with a direct oral anticoagulant discontinued on 22 October and recommenced on 16 November with a dosage for a thrombotic event. Mr Dimond died from a sudden catastrophic bleed from his ruptured iliac artery aneurysm with anticoagulation contributing to his excessive bleed.

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 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. – Evidence was heard that there were communication issues: (1) Treating Clinicians stated they were not aware of the diagnosis of Iliac Artery Aneurysm previously made at the Trust in August 2019 even though this was set out in the medical records and made at the same time as the diagnosis of Aortic Abdominal Aneurysm that was known. Abdominal surgery and anticoagulation were undertaken without consideration of this information. (2) The patient was discharged on 19 October 2022 with a new diagnosis of Atrial Fibrillation and prescription of Direct Oral Anticoagulant Apixaban was prescribed. The patient was not given any written advice on the risks as to bleeding on this medication and the risks were not shared with family on discharge. This led to advice being sought from 111 and a long delay before 999 was called when the patient deteriorated on 22 October 2022. (3) Anti-coagulation on readmission was considered complex and the advice of a Consultant Haematologist was sought but not followed on two occasions: (a) Beriplex and Vitamin K was administered. There was no rationale noted as to why advice to withhold Beriplex was not followed. (b) There was no record as to why advice to give prophylactic clexane was not administered. (4) The Consultant Haematologist confirmed that if information of the existence of an Iliac Artery Aneurysm had been shared, they would have sought the advice of a Consultant Vascular Surgeon.
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 18th December 2021. 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, [redacted] (Wife). I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**22nd October 2022** **Signature:** S. M. Hayes **Assistant Coroner North East Kent**