Regulation 28: Prevention of Future Deaths report

Roy Elton TRAVERS (died 06.06.22)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Executive Medical Director** **Whittington Health NHS Trust** **Whittington Hospital** **Magdala Avenue** **London N19 5NF**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 16 June 2022, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Roy Travers aged 89 years. The investigation concluded at the end of the inquest yesterday. I made a narrative determination (see below at section 4). Mr Travers' medical cause of death was: 1a) spontaneous bilateral subdural haematomas (on direct oral anticoagulation) 1b) atrial fibrillation, congestive cardiac failure, dementia and frailty.
4	**CIRCUMSTANCES OF THE DEATH**

	Roy Travers died on 6 June 2022 from a spontaneous cerebral bleed, a natural cause of death. When he was admitted to the Whittington Hospital on 2 June 2022 he was not scanned and so the bleed was not diagnosed at that point. This is probably because he had several co-morbidities that might have provided an infective cause. If the bleed had been diagnosed, his anti-coagulation therapy would have been withheld. It is unclear whether this would have changed the outcome.
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. Malaena was noted at 8.45am on 4 June 2022, but it was another 12 hours before medical staff reviewed Mr Travers. There appears to have been a failure to escalate. A doctor was asked to see him earlier that day, but about a different issue. 2. As identified at the Whittington 72 hour review, the reviewing doctor who later considered Mr Travers' condition in the light of the melaena, then failed to withhold his anti-coagulation therapy, apixaban. It is unclear from the review whether that doctor has since been given direct feedback and a learning opportunity. 3. The 72 hour review identified the need to discuss Mr Travers' care at the relevant morbidity and mortality meeting. It is unclear from the review whether that discussion has taken place. 4. Mr Travers' sons told me at inquest that, when Mr Travers' was nursed on Mary Seacole Ward, they felt that staff regarded this confused, elderly man as a nuisance. That is clearly unacceptable. In addition, Mr Travers' family worried that this view of him clouded the judgement of those looking after him. 5. As you will be aware, an ancillary function of every inquest is to attempt to learn lessons from the death, the driver behind prevention of future deaths reports. However, it is incumbent upon every hospital trust to consider the deaths of those within its care long before the matter comes to inquest, and to attempt to learn from these if possible. Whittington Health conducted a 72 hour review of Mr Travers' care on 17 June 2022.

	This was disclosed to my coroner's officer late on the afternoon of Friday, 4 November, in preparation for an inquest listed for 10am on Monday, 7 November. This meant that Mr Travers' family and I received the 72 hour review on the morning of inquest. This had several consequences. • It placed family members in an unfair position in terms of their preparation for inquest. • It did not comply with the duty to co-operate with HM Coroner, not simply when asked but also by volunteering all relevant information. • It denied HMC the ability to call to inquest any witnesses the need for whom only became apparent from the review. • And it did not inspire confidence that Whittington Health took its own review seriously and tried to learn from it. Even the Whittington consultant giving oral evidence at inquest only saw the review on the morning of inquest, and then purely as a result of being provided it by my coroner's officer.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 9 January 2023. 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 following. • [redacted], son of Roy Travers • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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	**DATE** 08.11.22	**SIGNED BY SENIOR CORONER** *ME Hassell*