REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Nottingham University Hospitals NHS Trust**
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 the 14th June 2022, I commenced an investigation into the death of Gordon Harry Renfrew. The investigation concluded at the end of the inquest on the 28th June 2023 The conclusion of the inquest was a Narrative as follows: Gordon Renfrew died on the 14th June 2022 at Queens Medical Centre Nottingham, from extensive cerebral oedema with mass effect leading to brain herniation. This was caused by a large cerebral infarction, occurring early morning on the 7th June 2022, and involving the anterior, middle and posterior lobes of the left cerebral hemisphere. The infarction was caused by a large occlusion in the left internal carotid artery in the neck, extending to the bifurcation of the internal carotid artery into the anterior and middle cerebral arteries. The occlusion was caused by arterial dissection and clot/thrombus at this site, likely caused by a combination of weakness in the arterial vessel wall from Fibromuscular Dysplasia, and a neck hyperextension injury sustained when diving from a high board on the 31st May 2022 A Mechanical Thrombectomy was undertaken on the 7th June 22, to try and remove the clot. This was partially successful, but there remained occlusion of the middle cerebral artery, with subsequent additional re-occlusion of the internal carotid artery post procedure. A Decompression Craniectomy was undertaken on the 10th June 2022, to try and reduce the effect of the severe cerebral oedema, caused by the large infarct The NICE guidance on Decompression Craniectomy after stroke, was not followed. There should have been detailed, early and repeated discussion with the family as to timing of the Decompression Craniectomy, on the 8th and 9th June 2022. Had this occurred it is very likely that the procedure would have been performed at an earlier time, although it is not possible to say, on a balance of probability, that this would have led to Gordon surviving what was a very severe and extensive stroke.

4	**CIRCUMSTANCES OF THE DEATH** Gordon died on the 14th June 2022, at Queens Medical Centre (QMC), Nottingham, after a short admission. He had been transferred to QMC, from the Royal Derby Hospital for further management of a severe and extensive stroke. Detailed findings as to how he came by his death are described within a written Determination dated 28.6.23, appended to this report
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 – • There is limited evidence to date of improved communication, and a stronger working relationship, between the stroke team and the neurosurgical team at the Trust • There is limited evidence to date of the Stroke team having a clear understanding of the NICE guidance regarding Decompression Craniectomy, specifically the importance of detailed careful monitoring post stroke, with clarity about referral criteria to Neurosurgery. The planned Standard Operating Procedure, which may set out this clarity is not yet finalised. • There are currently limited opportunities for joint case discussion and learning between the Stroke and Neurosurgical teams. The Interventional Neuroradiologists could of course also usefully participate in such Educational opportunities - I note it was [redacted], (Consultant in Interventional Neuroradiology) rather than the Stroke team, who asked that Gordon was reviewed by the Neurosurgical team on the early evening of the 7th June 2022 I am not reassured that necessary actions to address these serious issues identified are in place.
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 the **31st August 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 Chief Coroner and to the following Interested Persons:

	1. Gordons family- His partner [redacted], and his parents [redacted] 2. The University Hospitals of Derby and Burton NHS Foundation Trust 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 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 by the Chief Coroner.
9	**6the July 2023** **Dr E A Didcock**