Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive University Hospitals Sussex NHS Foundation Trust
1	**CORONER** I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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 17 November 2022 I commenced an investigation into the death of Alison Mary ROSS aged 55. The investigation concluded at the end of the inquest on 20 September 2023. The conclusion of the inquest was that: Alison Mary Ross died on 11 November 2022 at the Princess Royal Hospital, Lewes Road, Haywards Heath, West Sussex from an intraabdominal haemorrhage caused by an ascitic drain procedure on 10 November 2022 to treat ascites resulting from decompensated chronic alcoholic liver disease.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Ross was admitted to hospital on 3 November 2022 and was found during admission to have abdominal ascites. On 9 November 2022 Mrs Ross was prescribed treatment doses of apixaban commencing on 10 November. This replaced the prophylactic dose of enoxaparin given previously. At the time of the prescription of apixaban she had been diagnosed with a DVT. She had an ascites drain inserted on 10 November 2022. At the time of the procedure Mrs Ross' platelets were within normal range and she had an INR of 1.3 which was slightly above the normal range. Mrs Ross reported to the clinician during the morning ward round that she had not taken her oral medications that morning as she was too unwell. These were charted as including apixaban. There was also a Nurse present at that time. The clinician advised the Nurse and Mrs Ross that the anticoagulation would be stopped for 48 hours due to the procedure and charted this accordingly. The clinician inserted the drain at 13:30 without any reported complications. At 15:30 the clinician reviewed Mrs Ross with the drain still in situ. The Nurse who had been at the ward round was also present. At that time Mrs Ross reported relief from her symptoms and that she had since the start of the procedure taken her morning medications. There was no evidence that apixaban was omitted. There was no evidence as

	to what had happened to the medications that were not taken when dispensed. The clinician administered Tranexamic acid (TXA) and Vitamin K as preventative medications to mitigate the effects of the apixaban. At that time there were no clinical indications of bleeding. Around 30 minutes after the drain had been removed Mrs Ross started to demonstrate symptoms which may have been indicative of a bleed having occurred. Despite treatment to try and increase Mrs Ross' clotting due to the location of the bleed she said died from the haemorrhage.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: It was brought to my attention that the competencies for those involved in medicine administration stated that medications should not be left at the bedside, but no guidance for the monitoring of medication for those patients who self administer prescriptions dispensed to them who do not take their medication at the time of dispensing it.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 November 16, 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 [redacted] 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	**Dated: 21/09/2023**

	J. Andrews **Joanne ANDREWS** **Area Coroner for** **West Sussex, Brighton and Hove**