REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF AUDREY KING

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Officer** **Royal Cornwall Hospital Trust (RCHT)**
1	**CORONER** I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 21 November 2022 I commenced an investigation into the death of Audrey King. The investigation concluded at the end of the inquest on 7 August 2023. The medical cause of death was found as follows *1a Ischaemic stroke* *1b Atrial Fibrillation* *II Femoral Hernia repair (Operated)* The four questions - who, when, where and how – were answered as follows … *Audrey KING died on 15 November 2022 at Royal Cornwall Hospital Truro Cornwall from a stroke following an operation, against a background of atrial fibrillation in which anti-coagulant medication was not re-started which likely contributed to the stroke.* The conclusion was as follows *Audrey died from complications following necessary surgery contributed to by not re-starting anti-coagulant medication after the operation.*

4	**CIRCUMSTANCES OF THE DEATH** Audrey had a previous medical history which included Atrial Fibrillation (AF), which was medicated by an anti-coagulant, apixaban, to reduce the risk of a stroke. On 6 November 2022, Audrey was admitted to RCHT with abdominal pain secondary to femoral hernia obstruction. The apixaban was suspended pending surgery. Audrey underwent surgery for femoral hernia repair, that same day, 6 November 2022. The operation was uneventful. On 9 November 2022 the eldercare consultant reviewed Audrey. The review notes were handwritten on paper medical notes. The eldercare consultant recommended that the surgical team restart Apixaban as soon as safe post operatively. The court heard evidence that the NICE guidance on this subject states *Stroke risk associated with atrial fibrillation; Post procedure with immediate and complete haemostasis NOACs can generally be resumed 6–8 h after the end of the intervention. Some surgical interventions carry increased bleeding risk in which case resume anticoagulation 48–72 h post procedure but at the earliest opportunity* The apixaban was not restarted. On 11 November 2022 Audrey had a severe stroke secondary to AF. Audrey died as a result of this complication four days later. The court found that whether and when to re-start the apixaban was a decision for the surgical team. The court heard that on the consultant surgeon's ward round his junior doctor colleague was briefing him, this included reference to the eldercare review paper notes. The junior doctor went through a number of aspects regarding care and treatment but did not refer to the recommendation to re-start apixaban. As a result, the consultant surgeon did not consider whether or not to re-start the apixaban. The court heard that the eldercare team use paper medical notes whilst the surgical team use a digital system, known as NerveCentre. The consultant surgeon stated that the digital system is easier for the surgical team to read because the consultant surgeons can look at the detail on their phone or iPad. The consultant surgeon considered that the different recording platforms contributed to the error of omission in Audrey's case. Where an 'important clinical note' has been handwritten in the handwritten record there is facility for highlighting this on the 'ward round' function on Nerve centre. There was no alert that clinical notes had been handwritten in the written notes following the review by the eldercare consultant on 9th November. The court found that apixaban was prescribed on admission and correctly suspended due to bleeding risk in light of pending surgery. There is no evidence of review of this suspension in either medicines reconciliation (10th November) or in the medical records. The court heard that there is no automatic flag on the Electronic Prescribing Medication Administration (EPMA) requiring review of the ongoing suspension of prescribed medication.
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) Inconsistencies in record keeping between specialities. (2) The process for entering an alert in the digital system that clinical notes have been handwritten in the written notes. (3) The absence of an alert on the EPMA requiring review of the ongoing suspension of prescribed medication.
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 17 October 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 family. I am also 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, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	 **Guy Davies** HM Assistant Coroner for Cornwall & the Isles of Scilly 22 August 2023