WORCESTERSHIRE CORONER AREA

REPORT ON ACTION TO PREVENT OTHER DEATHS
ANDREW ETLERED NICHOLS

HM ASSISTANT CORONER
NICHOLAS H LANE

	REGULATION 28 – REPORT ON ACTION TO PREVENT OTHER DEATHS THIS REPORT IS BEING SENT TO: 1) Chief Executive, National Institute for Health and Care Excellence (NICE) [redacted]
1	CORONER I am Nicholas H Lane, HM Assistant Coroner for Worcestershire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 7 July 2022 an investigation was commenced into the death of Andrew Etlered Nichols. The investigation concluded at the end of the inquest hearing on 25 October 2023 at Stourport Coroner's Court, in the Worcestershire Coroner Area. The conclusion (a 'narrative' conclusion in Section 4 of the Record of Inquest) was determined as follows: *'Andrew Nichols died as a direct result of blood clots forming in the vein of his leg and circulating to block the veins of his lungs.* *Andrew not receiving anticoagulation medication when discharged from hospital contributed to his death.* *Andrew's immobility, which had occurred as a result of a very rare side-effect following vaccination, contributed to his death.'*
4	CIRCUMSTANCES OF THE DEATH Andrew Nichols was in his early fifties (he was 52 when he died in June 2022), with no significant past medical history, when he received a vaccination in April 2021, as part of the national programme in response to the Covid-19 pandemic. Andrew suffered an extremely rare and serious side-effect of vaccination, and within days developed the neurological condition acute disseminated encephalomyelitis (known as ADEM). In consequence, Andrew spent over a year in hospital, mostly in intensive care, as he required respiratory, nutrition and organ support and was wholly dependent on professionals for daily care. Andrew was immobile and required hoisting when being moved out of bed. Early on in his hospital admission, Andrew suffered bilateral pulmonary emboli, which were thought to have developed owing to him having become acutely unwell and immobile (not vaccine-induced thrombotic thrombocytopaenia (VITT)). Andrew was commenced on anticoagulation medication and this continued during his stay in hospital. At the inquest, evidence was given by a consultant haematologist, who stated that, owing to Andrew having two specific risk factors for the development of deep vein thrombosis (namely ongoing immobility

	and previous thrombosis/emboli), anticoagulation medication would remain clinically indicated, whether he remained in hospital or not. In May 2022, Andrew was discharged from hospital to a specialist neuro-rehabilitation community care centre. Upon discharge, the hospital did not include anticoagulation medication in the list of prescribed medication that Andrew should continue to receive in the community. At the inquest, the hospital accepted that to not do so was a failing on their behalf. It was not clear why this failing happened; however, a finding was made that the most likely reason was that clinicians routinely considered anticoagulation medication was prescribed for patients in hospital, but an assessment of whether it would continue to be required in the community would be made by professionals involved there. Andrew attended a different acute hospital on two further occasions (these were short admissions to provide respiratory support and to treat and monitor infection) later in May, and then in June 2022 – once again, Andrew received anticoagulation medication during his stay in hospital, but not upon discharge. The inquest heard that the neurorehabilitation community care centre did not, at the time of Andrew's death, perform their own assessments on new patients' risk of venous thrombosis (VTE risk assessment), but instead were reliant on information being provided by hospitals and would facilitate prescribed medication being given to patients (including anticoagulation medication), in accordance with discharge information. The centre now has a new policy in place, requiring VTE risk and assessment to be considered when patients are discharged from hospital into their care. The inquest heard evidence from the Director of Services at the centre, who stated that she had spoken to colleagues at other similar community care organisations, who also did not routinely carry out VTE risk assessments on patients, as part of their practice. Andrew suffered a fatal deep vein thrombosis and pulmonary embolism at the neurorehabilitation centre on 27 June 2022. Following medical evidence heard at the inquest, the cause of death was determined in Section 2 of the Record of Inquest as: *1a – pulmonary embolism* *1b – deep vein thrombosis* *2 – acute disseminated encephalomyelitis (vaccine-induced)* Section 3 of the Record of Inquest (which answered how, when and where Mr Nichols came by his death) was determined as follows: *'Andrew Nichols had no significant medical history at the time he received a vaccination in April 2021, as part of the national programme in response to the Covid-19 pandemic. Within a few days, Andrew became very unwell and was diagnosed with acute disseminated encephalomyelitis (ADEM), a severe neurological condition which had developed as a side-effect of vaccination. Andrew received specialist care for over a year, primarily in hospital, but latterly at a neuro-rehabilitation centre. Andrew had been prescribed anticoagulant medication whilst in hospital, owing to his immobility and risk of developing blood clots. Andrew should have continued to receive this medication, however, upon discharge from hospital to the rehabilitation centre, he did not. Andrew became acutely unwell on 27 June 2022, going into cardiac arrest. Despite prolonged attempts at resuscitation by nursing and paramedic professionals, Andrew was pronounced deceased later the same day, upon arrival at the Worcestershire Royal Hospital.'*
5	<u>CORONER'S CONCERNS</u> During the course of the investigation and 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)** There seems to be a lack of clarity amongst health and care professionals (certainly those who gave evidence at this inquest) as to whether community organisations receiving patients following discharge from hospital (such as neurorehabilitation centres and care homes) should, as a routine part of their responsibilities, be performing VTE risk assessments.

	I was referred to *NICE Guidance 89 (Venous thromboembolism in Over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism – published March 2018, updated August 2019)*, which deals with VTE assessment and procedure for hospital patients, but there is no reference in this guidance to assessments in the community. There is reference in the guidance to patients about to be discharged (paragraph 1.2), but this appears to cover the practicalities of situations where a firm decision has already been made by hospital clinicians that anticoagulation will continue. I am concerned that hospital clinicians may not be routinely performing VTE assessments as part of discharge planning, on the basis that they believe such assessment will occur in the community placement. However, it is unclear whether (and, based on evidence heard at the inquest, unlikely that) many community organisations are performing such assessments, and instead most will be relying on hospitals to do this. I am concerned that, as a result, as happened to Andrew, some patients will not have their VTE risk considered when they move from being an in-patient to residing in a community setting. Consideration could be given to making the NICE guidance (NG 89) clearer in respect of the respective responsibilities placed on hospital and community organisations, when a patient is to be discharged from one to the other. Consideration could also be given to the desirability of separate guidance covering VTE risk assessment in community settings, and the potential importance of this to certain groups of patients, particularly those who are immobile and requiring long-term community care. **2)** Having heard evidence at the inquest, it was unclear what pathways exist to ensure that organisations come to know of relevant NICE guidance that does, or may, apply to them. Taking a neurorehabilitation community care centre as an example, some NICE guidance will be completely irrelevant to their practice and need not be considered at all (e.g., NG229 – fetal monitoring in labour), some will be of direct relevance and will require careful consideration (e.g., NG211 – Rehabilitation after traumatic injury), and many others might contain relevant and useful information. Most organisations will have professionals employed in positions (such as Medical Directors or Directors of Safety and Learning) where they (as part of their specific employment responsibilities and through undertaking relevant CPD) will often come to know of relevant guidance and will disseminate accordingly, however this may not always be the case or work as one would hope, particularly perhaps in smaller community-based organisations. Consideration could be given to how NICE shares guidance documents and other relevant information with relevant organisations and whether there exists a sufficient chain of accountability in respect of this.
6	<u>ACTION SHOULD BE TAKEN</u> In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	<u>YOUR RESPONSE</u> Your organisation is under a duty to respond to this report within 56 days of the date of this report, namely by **22 December 2023**. I, the coroner, may extend this period. If any request is to be made for this period to be extended, please ensure this is made in writing at least 14 days prior to the above required response date. 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	<u>COPIES AND PUBLICATION</u> I have sent a copy of my report to Interested Persons – these being:

	- the family of Andrew Nichols - University Hospitals Birmingham NHS Trust - Inspire Neurocare Worcester - Medicines and Healthcare Products Regulation Agency (MHRA). I have also sent a copy of my report to the Chief Coroner. 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	Date: 27 October 2023 Signature:  **Nicholas H Lane** **HM Assistant Coroner for Worcestershire**