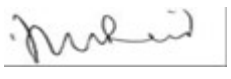
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) [redacted], Chief Executive, National Institute for Health and Care Excellence; 2) [redacted], Chief Executive Officer, British Society of Gastroenterology 3) [redacted], National Medical Director, NHS England;
1	**CORONER** I am David Donald William REID, HM Senior 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 16 August 2023 I commenced an investigation and opened an inquest into the death of Terence William SULLIVAN. The investigation concluded at the end of the inquest on 28 February 2024 The conclusion of the inquest was that Mr. Sullivan *"Died as the result of complications of necessary surgery, to which the temporary cessation of anticoagulation medication contributed."*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mr. Sullivan come by his death?", I recorded as follows: *"On 8.8.23 Terence Sullivan underwent a surgical procedure at Worcestershire Royal Hospital to remove a polyp from his sigmoid colon. Mr. Sullivan had been on anticoagulant medication following a previous diagnosis of atrial fibrillation and the insertion of coronary artery stents, and this medication was temporarily suspended so that the procedure on 8.8.23 could go ahead. Following the procedure, Mr. Sullivan suffered an acute myocardial infarction caused by a blockage in a coronary artery stent. Despite treatment, he continued to decline and died in hospital on 10.8.23."*
5	**<u>CORONER'S CONCERNS</u>** 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) Since June 2023, Mr. Sullivan had been on a single anticoagulant medication (Rivaroxaban) to prevent previously inserted coronary stents from blocking. The clinicians who carried out the endoscopic procedure on 8.8.23, however, ensured that he had not taken any Rivaroxaban for the previous 48 hours. This was in accordance with Worcestershire Acute Hospital NHS Trust

	(WAHT)'s own guidance, itself based on NICE guidance *"NICE Clinical Scenario: Rivaroxaban for a therapeutic endoscopy"*. I also heard evidence that the equivalent guidance from the British Society of Gastroenterology (BSG) provided similar advice. At inquest, I heard evidence from WAHT's Clinical Director for Critical Care that none of the aforementioned guidance considered the specific, and increasingly more common, scenario of a patient with coronary stents who is on a single (as opposed to more than one) anticoagulant medication, and who requires a therapeutic endoscopic procedure. The Clinical Director felt that in those specific circumstances, best practice requires pre-operative consultation with an interventional cardiologist, to decide on the best anticoagulation strategy during the procedure. I am concerned to hear that current guidance on this specific issue from both NICE and BSG may not now reflect current best practice.
6	**ACTION SHOULD BE TAKEN** 1) In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the National Institute for Health and Care Excellence (NICE), the Chief Executive Officer of the British Society of Gastroenterology (BSG), and the National Medical Director of NHS England respectively, 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 **8 May 2024.** 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: (a) [redacted], Mr. Sullivan's daughter. 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	**13 March 2024**  **David REID** **HM Senior Coroner for Worcestershire**