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:** **1 National Institute for HEALTH AND CARE EXCELLENCE**
1	**CORONER** I am Sophie LOMAS, Assistant Coroner for the coroner area of Derby and Derbyshire
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 13 January 2023 I commenced an investigation into the death of Michael BRIGGS aged 79. The investigation concluded at the end of the inquest on 21 March 2024.
4	**CIRCUMSTANCES OF THE DEATH** On 7th November 2022 Michael Briggs consulted with his dentist as to undergoing dental extractions due to pain. He was advised to discuss the safety of such a procedure with his GP as he was taking anticoagulants. On 26th November he returned to his dentist and, having indicated to the dentist that there were no issues with him undergoing the procedure, he proceeded to have three extractions. The procedure was uneventful, and he returned home to recuperate. On 30th November 2022 Mr Briggs was admitted to A & E with a fever and reported a history of bleeding following the extraction. Blood cultures confirmed the presence of staphylococcus aureus and, as Mr Briggs had a bio-prosthetic aortic valve, it was suspected that he had developed infective endocarditis. The diagnosis was confirmed by Trans-oesophageal Echo on 14th December 2022 and he was treated with antibiotics. Despite treatment his condition continued to deteriorate. He was recognised as approaching the end of his life and sadly died at Royal Derby Hospital on 11th January 2023. The court heard evidence that infective endocarditis is a recognised complication of invasive dental procedures for those who have certain underlying health conditions such as valve replacements. For such patients the provision of antibiotic prophylaxis may reduce the risk of developing infective endocarditis. On the evidence before the court, it is not possible to determine whether prophylactic antibiotics would have made a difference to the outcome in Mr Brigg's case. Narrative conclusion: Michael Briggs died due to recognised complications arising from a dental extraction procedure.
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: (brief summary of matters of concern)

	The matters of concern arise in the context of patients who are at increased risk of infective endocarditis following dental procedures and whether such patients should be given antibiotic prophylaxis. At inquest the court heard evidence that there is limited guidance available for dentists in England and Wales on how to manage such patients. The evidence heard at inquest gives rise to the following matters of concern: • The NICE guideline GC64 "Prophylaxis against infective endocarditis" states that antibiotic prophylaxis against infective endocarditis is not recommended routinely for people undergoing dental procedures. The guideline does not provide any implementation advice for dentists on how they should manage patients who are at an increased risk. • The Scottish Dental Clinical Effectiveness Programme (SDCEP) produced implementation advice in August 2018 entitled "Antibiotic Prophylaxis Against Infective Endocarditis". The document contains a "NICE Statement of Endorsement" that the advice supports the implementation of recommendations in GC64. There is no reciprocal endorsement or mention of the SDCEP advice in GC64 and there does not appear to be any such implementation advice applicable to dentists in England and Wales. • In 2023 the European Society of Cariology (ESC) produced Clinical Practice Guidelines for the management of endocarditis which recommends antibiotic prophylaxis for high risk individuals. The court heard evidence that cardiologists in England and Wales are regularly following this guidance which conflicts with the 2016 NICE guideline.
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 May 31, 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 Interested Persons [redacted] **DENTIST** **Royal Derby Hospital - Legal Services** 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: 18/04/2024**

	 **Sophie LOMAS** **Assistant Coroner for** **Derby and Derbyshire**