# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 Sussex Community Dermatology Service**<br>**2 British Society of Dermatological Surgery** |
| **1** | **CORONER**<br><br>I am Karen HENDERSON, Assistant Coroner for the coroner area of West Sussex, Brighton and Hove |
| **2** | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7(1) of Schedule 5, of the Coroners and Justice Act 2009. |
| **3** | **INVESTIGATION and INQUEST**<br><br>On 21st February 2024 I concluded an investigation into the death of Dr Alan William Kingsbury.<br><br>The medical cause of death recorded was:-<br><br>1a Pneumonia<br><br>1b Fractured right neck of femur (repaired surgically 21/10.23)<br><br>1c Fall secondary to anaemia, secondary to bleeding chest wall lesion (excised squamous cell cancer 19.10.23)<br><br>3 Severe frailty of Old Age<br><br>I returned a narrative conclusion:<br><br>Dr Alan William Kingsbury was extremely frail with poor physiological reserve. On the 19th October 2023 he was admitted into Worthing Hospital, Worthing as an emergency for excessive bleeding secondary to an excision of a left cutaneous chest lesion (squamous cell carcinoma in situ) earlier that day whilst anticoagulated with aspirin and clopidogrel.<br><br>In the early hours of 21st October 2023 Dr Kingsbury had a fall in the hospital in circumstances whereby neither a sitting and lying blood pressure or a falls assessment had not been undertaken. He sustained a right neck of femur fracture requiring surgical repair later that day alongside further surgical revision of the chest wound for dehiscence and ongoing bleeding.<br><br>The combination of frailty, ongoing bleeding from the chest wound and complications of the fall all contributed to his death at the hospital on 29th October 2023 |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>The conclusion reflects the circumstances of Dr Kingsbury's death. |

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| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>**1. BSDS (British Society of Dermatological Surgery) Guidelines on Anti-thrombotics and skin surgery for dermatological excisions in the community**.<br><br>The guidelines as to the suitability of maintaining patients' anti-thrombotic medication prior to surgical excision are insufficiently robust to reflect bleeding potential from a myriad of factors including the condition of the skin being excised, the position of the lesion and the underlying frailty and medical co-morbidites of individuals requiring dermatological surgery in the community. Dr Kingsbury was extremely frail taking Aspirin and Clopidogrel. The lesion to be excised was on the upper chest wall with extremely fragile skin and the excision was larger than expected with some difficulty in obtaining primary closure.<br><br>**2. The lack of a Preoperative assessment and advanced consent**<br><br>Dr Kingsbury was not assessed or consented either in person or by telephone consultation prior to the day of the procedure against current accepted guidelines for surgical procedures. No risk/benefit analysis was undertaken as to the suitability of undertaking the procedure whilst Dr Kingsbury was taking Aspirin and Clopidogrel. Mrs Kingsbury made multiple attempts at communicating with the service without success to obtain advice as to the necessity or otherwise of discontinuing the anticoagulants.<br><br>**3. Guidance as to the appropriateness of the surgical technique for wound closure**<br><br>Evidence was heard that due to the fragility of the skin the initial wound closure was not sufficiently deep to effectively achieve haemostasis, requiring closure at a muscular level with different suture technique. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th September 2024. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>[redacted] **Consultant Dermatologist, Worthing Skin and Laser Clinc**<br>[redacted] **Orthopaedic Surgeon. University Hospitals Sussex NHS Foundation Trust** |

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| | 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.<br><br>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.<br><br>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: 08/07/2024**<br><br>  <br>**Karen HENDERSON**<br>**Assistant Coroner for**<br>**West Sussex, Brighton and Hove** |