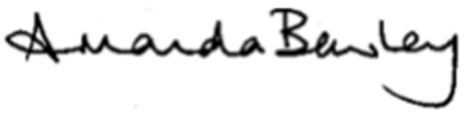
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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 Amanda BEWLEY, HM Assistant Coroner for the coroner area of Nottingham City and Nottinghamshire
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 10 May 2023, I commenced an investigation into the death of Ruth Diane Eggleton. The investigation concluded at the end of the inquest on 2 July 2024. The conclusion of the inquest was a narrative conclusion: Ruth Diane Eggleton fell whilst gardening, sustaining a head injury. Rivaroxaban was not withheld or reversed, and Mrs Eggleton was discharged from hospital on 2 April 2023, both of which more than minimally, negligibly or trivially contributed to her death from traumatic subdural haemorrhage.
4	**CIRCUMSTANCES OF THE DEATH** On 2 April 2023, Ruth Diane Eggleton fell in her garden, sustaining a brain injury. A CT head scan undertaken on 2 April 2023 revealed a small subdural haemorrhage. Mrs Eggleton was anticoagulated with Rivaroxaban which was neither reversed nor discontinued on 2 April 2023. Mrs Eggleton was discharged from hospital on 2 April 2023. Had Mrs Eggleton remained in hospital for neurological observations in accordance with NICE guidelines, she would have more than likely survived as those observations would have revealed Mrs Eggleton's deterioration early on which would have led to reversal and cessation of Rivaroxaban, and allowed for surgical evacuation of the haemorrhage before Diane was too neurologically compromised. The subdural haemorrhage continued to ooze, contributed to by ongoing anticoagulation with Rivaroxaban. The continuation of Rivaroxaban more than minimally contributed to Mrs Eggletons' death.

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) 1. There is a lack of evidence-based protocol for determining when to withhold and/or reverse DOAC, and when to prescribe alternative anticoagulant medication. I heard evidence from clinicians that the lack of such a protocol has led to divergence of practice amongst clinicians. I am not reassured that necessary actions to address the serious issue identified are in place.
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 August 27, 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] **Doncaster & Bassetlaw Teaching Hospitals** **Sheffield Teaching Hospitals** I have also sent it to **Department of Health and Social Care DHSC** **The Royal College of Surgeons** **The Society of British Neurological Surgeons** **Royal College of Pathologists** **British Society of Haematology** **Royal Society of Medicine** **The Royal College of Physicians** **British Cardiac Society** who may find it useful or of interest. 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: 03 July 2024**  **Amanda BEWLEY** **HM Assistant Coroner for** **Nottingham City & Nottinghamshire**