IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Jeffrey MARSHALL
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • [redacted], Chief Executive, NHS England • [redacted], Chief Executive, National Institute for Health and Care Excellence
1	**CORONER** Ms Anna Loxton, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Jeffrey MARSHALL** was opened on 4th January 2024. Evidence was heard and the inquest was concluded on 13th June 2024. Mr Marshall died at St Peter's Hospital in Chertsey on 13th December 2023, aged 72 years. I found the medical cause of death to be: 1a. Ischaemic Stroke 1b. Thrombosis of Basilar Artery 1c. Atherosclerosis of Basilar Artery 2. Previous Subdural Haematoma; Hypertension; Diabetes Mellitus; Atrial Fibrillation; Cessation of Anticoagulation Therapy I found that whilst the cause of death was natural, it was contributed to by the withholding of anticoagulation therapy over the previous 47 days prior to death. Mr Marshall had sustained a subdural haematoma in a fall on 21st October 2023, following which his anticoagulation therapy was

	withheld pending further CT scan to check that this had resolved before recommencing anticoagulation. Whilst a further CT scan took place on 8th November 2023, this was not reported until 3rd December 2023, and Mr Marshall's GP was informed by the Hospital that his anticoagulation should be recommenced on 6th December 2023. Mr Marshall suffered an ischaemic stroke on 7th December 2023 as a result of thrombosis of the basilar artery, of which he was at increased risk due to the withholding of anticoagulation therapy. He deteriorated until his death. I heard evidence from a Stroke Consultant at Ashford and St Peter's Hospitals NHS Foundation Trust that the half-life of Direct Oral anticoagulants is short and therefore the benefit of its risk reduction for thrombus is lost within a short period of time, placing the patient at high risk of stroke. She detailed that whilst it is standard protocol to withhold anticoagulation following a head injury, there is no national guidance (e.g. from the National Institute for Health and Care Excellence) to assist in determining when anticoagulation should be recommenced. There is also no guidance for clinicians to discuss the withholding of anticoagulation and the risks/benefits of this with patients, to enable them to make an informed decision as to when to recommence anticoagulation in this scenario. I recorded a narrative conclusion of Natural Causes contributed to by withholding of anticoagulation over 47 days following subdural haematoma.
4	**CIRCUMSTANCES OF THE DEATH** Mr Marshall died from an ischaemic stroke at St Peter's Hospital in Chertsey on 13th December 2023. He had suffered a fall whilst exiting a car on 21st October 2023, in which he sustained an acute subdural haematoma. His anticoagulation therapy of Edoxaban, prescribed for atrial fibrillation and permanent pacemaker, was withheld in accordance with NICE guidance. Neurosurgeons at St George's Hospital in Tooting gave advice and reiterated the need to withhold anticoagulation and to monitor the bleed via further CT scan the following day, and again two weeks thereafter. The last scan on 8th November 2023 revealed that the haematoma had resolved, but this was requested on a routine basis with a reporting time of 28 days. It was therefore reported on Sunday 3rd December, and Mr Marshall's GP was advised that anticoagulation could be restarted on 6th December 2023. Mr Marshall suffered a sudden loss of consciousness at home on the evening of 7th December 2023 and was admitted to St Peter's Hospital, where he was found

	to have suffered a Basilar Artery Thrombosis and Basilar Territory Infarction. His anticoagulation had been withheld for 47 days on a background of atrial fibrillation and permanent pacemaker, increasing his risk of thrombus development. Mr Marshall's stroke was not survivable and he died on 13th December 2023.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: - Mr Marshall was prescribed anticoagulation (Edoxaban) to mitigate his increased risk of developing thrombus due to atrial fibrillation and a permanent pacemaker; - Anticoagulation was withheld following a traumatic head injury, in accordance with NICE guidance; - There is no national guidance to assist clinicians in determining when anticoagulation should be recommenced in this scenario, nor any recommendation for clinicians to discuss the risks and benefits of withholding anticoagulation with patients to enable them to make an informed decision as to when to recommence anticoagulation. Consideration should be given to whether any steps can be taken to address the above concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. See names in paragraph 1 above

	2. [redacted] 3. Ashford & St Peter's Hospitals NHS Foundation Trust 4. The Chief Coroner In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: **ANNA LOXTON** **DATED this 13th day of August 2023**