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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **Medical Director, Royal Cornwall Hospital**
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 8/10/24, I concluded the inquest into the death of David Charles Martin who died in RCHT on 17/9/22. I recorded the cause of death as: 1a) Left ventricular cardiac failure (post-stenting) 1b) Coronary artery thrombosis 1c) Coronary artery disease II) Atrial fibrillation; Chronic kidney disease I recorded a conclusion of Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Martin was an 83-year-old man with a history of progressive heart failure. He was admitted into Royal Cornwall Hospital on 30/8/22 with deteriorating symptoms. He had a diagnostic angiogram on 5/9/22 before a decision was made at a cardiology MDT on 12/9/22 that he was not for surgical intervention and was offered stenting (PCI) instead. The procedure took place on 16/9/22. It was Trust policy that patients undergoing PCI should have dual anti-platelet therapy (DAPT.) In error, Mr Martin was prescribed Aspirin only and the oversight was only identified post-operatively when Mr Martin was immediately given a loading dose of a second anti-platelet therapy. Mr Martin collapsed later that afternoon. He was resuscitated but then deteriorated and died in the hospital on 17/9/22. It is unlikely the cause of Mr Martin's collapse was a clot in an inserted stent and thus the oversight in the provision of a second anti-platelet therapy was not causative of Mr Martin's demise.

5	**CORONER'S CONCERNS** During the course of these inquests, the evidence has 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) The inquest heard evidence that the locum SHO involved in the care of Mr Martin was 9 days into a 3-4 month period of cover. She had not received any cardiology induction and was unaware of the Trust DAPT policy regarding PCI patients. It was accepted that while it was a challenge to ensure locums who covered 1-2 shifts had a thorough induction, where one was being asked to work in the service for an extended period of time, it was necessary that there was a proper induction process. The inquest heard changes have already been made in this regard. 2) There were multiple opportunities where the fact Mr Martin was receiving Aspirin only was not recognised. This included the completion of a WHO checklist intended to identify issues of this nature. Of greater concern is that a Deputy Sister who completed the cardiac cath lab pack did recognise the oversight but this was still not acted upon by medical colleagues.
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. The inquest heard from Matron [redacted] as well as Drs [redacted] and [redacted]. All felt changes could be made to the cardiac cath lab pack and the WHO checklist that would make the process more robust and prevent similar instances in the future.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 December 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: - The family of Mr Martin 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	**[DATE]** **[SIGNED BY CORONER]** **8/10/24**