The Inquest Touching the Death of Pamela Anne Marking
A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

- **Chief executive, NHS England**
- **National Medical Director, NHS England**
- **Chief Medical Officer, England**
- **Health Secretary, Department of Health**
- **Chief Executive, CQC**
- **President - GMC**
- **President - Royal College of Anaesthetists**
- **President - Association of Anaesthetists of GB and Ireland**
- **President – Difficult Airway Society**
- **President - Royal College of Emergency Medicine**
- **President - Royal College of Physicians**
- **Chief Executive, Surrey and Sussex Healthcare NHS Foundation Trust**

CORONER
Dr Karen Henderson, HM Assistant Coroner for Surrey

CORONER'S LEGAL POWERS
I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

INVESTIGATION and INQUEST

On 16th December 2024 I resumed the inquest into the death of Mrs Pamela Anne Marking. On 19th December 2024 I concluded the Inquest. At the time of her death Mrs Marking lived independently and was 77 years of age.

The medical cause of death given was:

1a Respiratory failure and Sepsis

1b Aspiration of feculent gastric contents at induction of anaesthesia

1c. Strangulated femoral hernia

I found:

On 16th February 2024 Pamela Anne Marking - who was unable to give a complete history due to

cognitive issues - was admitted to the Emergency Department at East Surrey Hospital. Redhill from her home address after unknowingly vomiting blood-stained fluid, with right sided and suprapubic abdominal tenderness. She was diagnosed as having had an epistaxis (nosebleed) by a Physician Associate and discharged home later that afternoon without a medical review or direct medical supervision of the Physician Associate who had a lack of understanding of the significance of abdominal pain and vomiting and had undertaken an incomplete abdominal examination which would have been likely to have found a right femoral hernia. Mrs Marking re-presented to the Emergency Department two days later with grossly dilated small bowel obstruction due to an incarcerated right femoral hernia containing ischaemic bowel requiring emergency surgery later that evening. A rapid sequence induction (RSI) of anaesthesia to protect her airway from aspiration of gastric contents was undertaken with Total Intravenous Anaesthesia (Propofol and Remifentanil and thereafter Rocuronium), in the absence of cricoid pressure and with a nasogastric tube in situ attached to the only suction device. This approach was considered a commonly deployed and safe technique in the absence of updated national guidelines. On induction of anaesthesia, Mrs Marking aspirated feculent fluid resulting in respiratory failure in the immediate post operative period requiring re-intubation and intensive care input. Despite maximal support Mrs Marking died at East Surrey hospital, Redhill on 20th February 2024. The clinical management Mrs Marking had on her first admission and thereafter during the Rapid Sequence Induction materially contributed to her death.

CIRCUMSTANCES OF THE DEATH

Please see my findings above

CORONER'S CONCERNS

1. The term 'Physician Associate' is misleading to the public

Mrs Marking's son was under the mistaken belief that the Physician Associate was a doctor by this title in circumstances where no steps were taken by the Emergency Department or the Physician Associate to explain or clearly differentiate their role from that of medically qualified practitioners.

2. Lack of public understanding of the role of Physician Associate

Witnesses from the Trust gave evidence that a Physician Associate was clinically equivalent to a Tier 2 resident doctor without evidence to support this belief. This blurring of roles without public knowledge and understanding of the role of a Physician Associate has the potential to devalue and undermine public confidence in the medical profession whilst allowing Physician Associates to potentially undertake roles outside of their competency thereby compromising patient safety.

3. The right of patients and family to seek a second opinion

The lack of public knowledge that a Physician Associate is not medically qualified has the potential to hinder requests by patients and their relatives who would wish to seek an opinion from a medical practitioner. It also raises issues of informed consent and protection of patient rights if the public are not aware or have not been properly informed that they are being treated by a Physician Associate rather than a medically qualified doctor.

4. Lack of national and local guidelines and regulation of the scope of practice for a Physician Associate

A diagnosis of epistaxis was made by the Physician Associate without appreciating the relevance of the vomiting and lower abdominal discomfort and in the absence of understanding the need to undertake palpation of the groins in an abdominal examination in a patient who was unable to give a proper clinical history because of short term memory loss. No evidence was presented that the management of Mrs Marking was subject to a reflective practice review. Given their limited training and in the absence of any national or local recognised hospital training for Physician Associates once appointed, this gives rise to a concern they are working outside of their capabilities.

5. Lack of guidelines for direct supervision and consideration of an appropriate level of autonomy for Physician Associates

Whilst there were discussions with the 'supervising' consultant the Physician Associate was effectively acting independently in the diagnosis, treatment, management and discharge of Mrs Marking without independent oversight by a medical practitioner. This gives rise to a concern that inadequate supervision or excessive delegation of undifferentiated patients in the Emergency Department to Physician Associates compromises patient safety.

6. Lack of 'Updated' National Guidelines for Rapid Sequence Induction (RSI) of Anaesthesia for emergency surgery

Mrs Marking required a rapid sequence induction to protect her airway from aspiration of bowel contents as a consequence of small bowel obstruction. The consultant anaesthetist gave evidence that the 'traditional' use of consecutive syringes of induction agent and muscle relaxant was obsolete, and it was common practice locally and nationally to routinely undertake a RSI with Total Intravenous Anaesthesia, in the absence of updated local or national guidelines to support this practice.

7. Lack of 'Updated' National Guidelines to support the use of TIVA for RSI

Other than empirically increasing the rate of infusion of TIVA agents (Propofol and Remifentanil) no evidence was forthcoming as to the target range required to ensure and confirm an adequate depth of anaesthesia for patients or the length of time required prior to and following the administration of a muscle relaxant (Rocuronium) to facilitate intubation. This is despite TIVA being known to provide a slower onset of anaesthesia and approximately 50% of all anaesthetic related deaths are due to aspiration (NAP 4).

8. Lack of 'Updated' Guidelines for use of Cricoid pressure and other measures to protect the airway in a RSI anaesthetic

Evidence was heard that as cricoid pressure was ineffective it was not routinely applied for a RSI intubation. After aspiration on Induction, the only suction device was attached to the nasogastric tube giving rise to a possible delay in timely suctioning of the feculent aspirate which was in excess of two litres after intubation was achieved.

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 have the power to take such action.

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.

COPIES
I have sent a copy of this report to the following:

1. Mr Marking - Son

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:

Karen Henderson

DATED this 24th Day of February 2025