Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Chief Executive Officer University Hospital Southampton NHS Foundation Trust

1 CORONER

I am Jason PEGG, Area Coroner for the area of Hampshire, Portsmouth and Southampton

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 1st April 2020 I commenced an investigation into the death of Robert James GOODMAN aged 68. The investigation concluded at the end of the inquest on 15 December 2020. The conclusion of the inquest was:

Accident

4 CIRCUMSTANCES OF THE DEATH

The deceased died on 30th March 2020 at Southampton General Hospital, Tremona Road, Southampton, Hampshire.
The deceased suffered an unwitnessed fall on 29th March 2020 at Southampton General Hospital causing a head injury, at the time of the fall the deceased was mobilising to go the toilet. The deceased's head injury was not identified until 30th March 2020 when the deceased had a computerised tomography scan of the head which showed the presence of a subdural haematoma.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
When found on the floor the deceased stated that he had a head injury. The Trust has a policy for the assessment and early management of head injuries. The policy was, on the evidence, drafted in 2016. The Trust policy is said to reflect the National Institute for Health and Care Excellence guidance on the assessment and early management of head injuries.
The deceased was receiving the anticoagulant enoxaparine whilst in hospital.
The present Trust policy states that a computerised tomography scan of the head should be undertaken within 8 hours of the injury if a patient is receiving anticoagulant treatment.
The evidence suggested that enoxaparine is a "low dose anticoagulant" which did not place the deceased within the Trust policy where a computerised tomography scan should be provided within 8 hours of a head injury.
The Trust were not aware of the September 2019 variation in National Institute for Health and Care Excellence guidance which now advises that patients who are on <u>any</u> anticoagulant should have a computerised tomography scan within 8 hours of a head injury.
The Trust's policy does not presently reflect the National Institute for Health and Care Excellence revised guidance, in place since September 2019.
It was accepted in evidence that the deceased would have had a computerised tomography scan within 8 hours of a head injury if the revised National Institute for Health and Care Excellence guidance had been applied and reflected in the Trust policy.
The deceased's computerised tomography scan was undertaken 30 hours after the deceased had suffered a head injury.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 09 February 2021. 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]

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.

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Jason PEGG
Area Coroner for
Hampshire, Portsmouth and Southampton
Dated: 15 December 2020