REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **Norfolk and Norwich University Hospital** **Colney Lane** **Norwich** **NR4 7UY**
1	**CORONER** I am YVONNE BLAKE, Area Coroner, for the Coroner area of NORFOLK
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 27 August 2019 I commenced an investigation into the death of David Michael Potts aged 82 years. The investigation concluded at the end of the inquest on 19 November 2019. The conclusion of the inquest was a narrative detailing Mr Potts' fall at home and development of an Acute Subdural Haematoma. He was on Apixaban. It was recommended that he be given Beriplex to reverse the effects of the Apixaban. Cause of Death 1a) Hospital Acquired Pneumonia, 2 Right Subdural Haematoma.
4	**CIRCUMSTANCES OF THE DEATH** Mr Potts fell at home hitting his head. He was prescribed apixaban. When admitted it was discovered that he had an acute subdural haematoma. Specialist Neurology advice was sought and the treating doctor prescribed Beriplex to revers the effects of the Apixaban. This was ready the same day and available from the pharmacy. No-one followed this up and at one point it was thought it hadn't been given because he was having an x-ray so off the ward. In fact, he did not leave the ward for any radiology that day, but it appears there was no documentation about his whereabouts. In any event the Beriplex was not given for some time and his bleed extended. He stabilised enough to be transferred to a local unit for possible rehabilitation. He declined after transfer and died 7 days later.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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) That the prescription of Beriplex was not given in a timely manner. (2) That no-one checked that it had been given despite an extension of the bleed. (3) That no-one seemed to know why it was not given as ordered or where Mr Potts was on the day in question.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 20 January 2020. 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] (Executors). 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	**Dated: 26/11/2019** ..... **Yvonne BLAKE** **Area Coroner for Norfolk** **Norfolk Coroner Service** **Carrow House** **301 King Street** **Norwich NR1 2TN**