REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Sandwell Hospital and West Birmingham Hospital NHS Trust**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 21 December 2017, I commenced an investigation into the death of Mr Frank Hayward. The investigation concluded at the end of the inquest on 9 March 2018. The conclusion of the inquest was a short narrative conclusion of: Accidental death contributed to by neglect. The cause of death was: 1a Raised Intracranial Tension b Subdural Haematoma And Fracture Type II Odontoid Peg 2 c Fall
4	**CIRCUMSTANCES OF THE DEATH** i) On the 12 November 2017, Mr Hayward had a fall at home and sustained an odontoid peg fracture and subdural haemorrhage. His past medical history included: dementia, atrial fibrillation on rivaroxaban, chronic lymphocytic leukaemia and ischaemic heart disease. ii) He was admitted to Sandwell Hospital and a CT scan failed to initially identify the haemorrhage. In addition there was an inadequate examination to identify the fracture. iii) Anti-coagulation medication was stopped two days later on the 14 November 2017. His condition declined further and he complained of worsening neck pain and drowsiness. iv) A further urgent CT scan was requested on the 19 November and wasn't actioned until the 22 November which then revealed the bleed and also the fracture. v) He wasn't deemed suitable for surgical input and managed conservatively. vi) There were also delays in obtaining a suitable cervical collar for his neck and the family had to source and pay for one privately. This was due to

	staff sickness absence and relocation of the service department. vii) He sustained a further fall in hospital with no further recorded injuries on the morning of the 26 November 2017. viii) Sadly, his condition continued to decline further and he died on the 10 December 2017.
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. Evidence emerged during the inquest that there were failures to correctly assess and diagnose his injuries in the Emergency Department and there were missed opportunities to have him reviewed by Trauma and Orthopaedics team sooner. 2. There was also evidence of poor systems in place in providing a collar for the patient and poor communication between the Orthotics Department and ward based staff. In addition there was a significant delay in obtaining an urgent CT scan.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. 1. You may wish to consider further reviewing the guidance on managing patients with head injury and also guidance on when to image the neck. In addition, you may wish to review the systems in place in sourcing and stocking suitable collars for patients and timeliness. 2. You may also wish to consider reviewing the timeliness and systems in place for requesting urgent CT scans.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 May 2018. 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; Family. 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	**29 March 2018** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**