REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Enquiry Handling Team** **National Institute for Health and Care Excellence** **10 Spring Gardens** **London SW1A 2BU**
1	**CORONER** I am David Clark Horsley, Senior Coroner, for the Coroner area of Portsmouth and South East Hampshire.
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 25th February 2015 I commenced an investigation into the death of Thelma Doris Clarkson. The investigation concluded at the end of the inquest on 19th November 2015. The conclusion of the inquest was: Mrs Clarkson's medical cause of death was Acute Subdural Haematoma and I concluded that her death was due to an Accident. I enclose a copy of my Record of Inquest.
4	**CIRCUMSTANCES OF THE DEATH** On 10th February 2015 Mrs Clarkson fell in her home. She sustained a number of injuries, including head injuries. She was taken to Gosport War Memorial Hospital where her injuries were treated and she was discharged home that afternoon. Following her return home, her condition deteriorated and she was taken by ambulance that evening to Southampton General Hospital where examination determined she had sustained an inoperable head injury from her earlier fall. She died at Southampton General Hospital on 11th February 2015.
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. – Prior to her fall, Mrs Clarkson has for some time been prescribed and was taking the drug Clopidogrel for her long-standing heart disease. The British National Formulary warns that patients taking Clopidogrel are at risk of increased bleeding from trauma. However, I was told in evidence at the Inquest that under the NICE Head Injury Pathway which was in use at the time at Gosport War Memorial Hospital, had Mrs Clarkson been taking Warfarin she would have been sent to a larger hospital to have a CT scan of her head but the Pathway did not include Clopidogrel as a similar trigger for a CT scan - notwithstanding the risk of increased bleeding from head trauma. I was also told that, had Mrs Clarkson been sent from Gosport War Memorial Hospital for a CT scan, there is a strong possibility it would have revealed the extent of her head injury and her

	treatment - and its potential outcome - may have been different. I am therefore concerned that the NICE should consider whether its Head Injury Pathway should be amended to include taking Clopidogrel as a trigger for a CT scan in the same way as Warfarin presently does.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 22nd January 2016. 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: 1- Mrs Clarkson's family 2- Portsmouth Hospitals NHS Trust 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	**27th November 2015** **[SIGNED BY CORONER]** **Mr David Clark Horsley**