REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive of Oxford University Hospitals NHS Foundation Trust**
1	**CORONER** I am Gemma Brannigan, Assistant Coroner, for the coroner area of Oxfordshire.
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 22 September 2020 I opened an inquest into the death of **Mrs Anne Patricia Harper,** aged 78. The investigation concluded at the end of the inquest on 10 February 2021. The medical cause of death was: Ia Respiratory Failure Ib Rib Fractures with flail segments II Right pneumothorax, Interstitial Lung Disease, Spinal Fractures, Rheumatoid Arthritis, Hiatus Hernia Mrs Harper fell down the stairs at her home in the night on 13 September 2020. She was taken to A&E at the John Radcliffe Hospital, arriving at 2.15am on 14 September 2020. Due to her fragility and osteoporosis, she suffered extensive fractures. This included flail fractures of 10 of her ribs, her pelvis, clavicle, forearm and spine. She remained in A&E until 6.40pm. She developed respiratory failure and died at the hospital at 22.17hrs that evening. Conclusion: Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** The severe fractures injuries were caused by a fall down the stairs at home, on a background of severe co-morbidities, a history of previous fractures and osteoporosis.

The inquest today also explored the hospital care. Both of the NHS consultants gave candid evidence to the court about the care in the John Radcliffe Hospital on 14 September 2020. I note that this was during the Covid-19 pandemic which will have increased demand on the NHS services. I thank them for their written statements and their oral evidence, including the structured judgment review. I understand that the Trust decided that this case does not meet the threshold for a 'serious incident' investigation. The care was described, in places, as substandard, unsatisfactory and poor.

I accept the evidence given to me, that;

1. There was no trauma call, which would have resulted in consultant lead care in A&E, and a CT scan within 1 hour. In fact, the extremely serious injuries were underestimated and a CT scan was not performed until 3 hours after attendance. As a result, there was no team which 'owned' Mrs Harper for quite some time.

2. Mrs Harper remained in A&E for a long time. She arrived at 2.15am, and was not transferred to a ward until around 5.30pm, when she deteriorated. Because of the Covid-19 pandemic restrictions, her family were not allowed to be with her.

3. An MRI was performed in the afternoon. I heard that the purpose of this was unclear, because it was unlikely to change the plan for her care.

4. No observations were recorded for around 6 hours between 11.10am and 5.20pm. I heard that she would have been connected to an oxygen monitor.

5. The prognosis could have been identified in the morning, once the results of the CT scans were known. Each specialty attended to review her, but I heard that the overview and co-ordination of her care was missing. The end of life decision was not made until she arrived on a ward in the evening. As a result, her Son and other family members were not informed, so could not be with her before she died.

6. In relation to analgesia, I heard that her injuries were causing her pain when the paramedic attended (Entonox and 10mg of morphine was given). From the time of her arrival in hospital, until her death 20 hours later, she was given a total of 2g paracetamol and 2.5mg IV morphine. Her pain score was not properly recorded. Between midday and 5.20pm no analgesia was administered and no physiological observations were recorded during this time. I accept the evidence that if she had been on a ward at this time, instead of in in A&E, her analgesia would have been likely to have been better managed. I accept the evidence from the doctor; that the analgesia administered was likely to be insufficient.

7. The trauma consultant sought regional analgesia (in accordance with policy),

	but because there were no ICU bed, ward bed or anaesthetists available (which I heard is not uncommon), this could not be administered. The Pain Team later confirmed that they could not attend in A&E. There was no adequate alternative plan made for analgesia. I accept that from the point at which Mrs Harper fell and sustained extensive and severe injuries, it was unlikely that she would survive. The only real option, after investigation, was to make her comfortable using a regional block and/or other analgesia. I heard that Mrs Harper was only able to take shallow breaths due to the pain. I asked about the relationship between the multiple flailing rib fractures, the insufficient analgesia and her eventual respiratory failure. The medical evidence from the anaesthetist was that a regional block would not have been sufficient in any event, given the extent of the damage to the rib cage, and that adequate analgesia would have been unlikely to have avoided the respiratory failure and death occurring when it did. The Trust gave evidence that action has been taken since this death to improve in some of the areas identified above, including that; 1. The Pain Team can now attend in A&E 2. The Trust policy on management of blunt chest trauma has been updated, so that if/when regional anaesthesia is not available immediately, that an alternative plan for analgesia is clear, which may include a patient controlled anaesthesia (PCA).
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. I heard evidence that a Major Trauma Centre is expected to have a major trauma lead consultant, and a trauma co-ordinator (in accordance with NICE guidelines). I understand that the Trust does not have these posts and that this has been the position since at least 2018.
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 9 April 2021. I, the coroner, may extend the period – I appreciate that because of the pandemic you may wish to request more time.

	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]) and to the CQC. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**12 February 2021** **Ms G Brannigan**