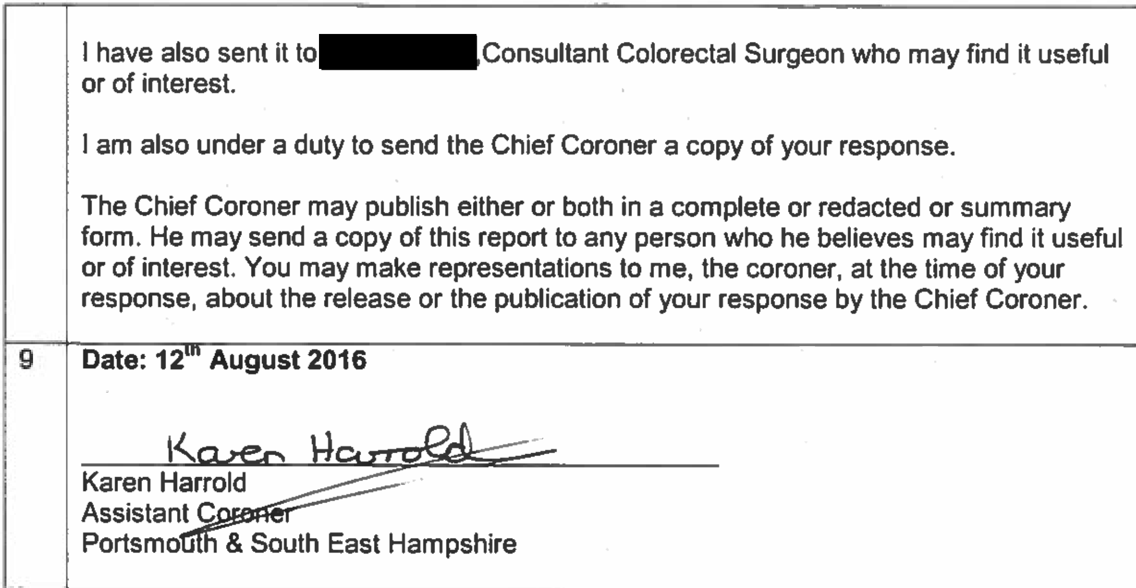
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Interim Chief Executive Portsmouth Hospitals NHS Trust Queen Alexandra Hospital Southwick Hill Road Cosham PO6 3LY
1	**CORONER** I am Karen Harrold, Assistant Coroner for the coroner area of Portsmouth & 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5 http://www.legislation.gov.uk/uksi/2013/1629/made
3	**INVESTIGATION and INQUEST** On 3rd March 2016, the Senior Coroner, David Horsley, commenced an investigation into the death of Michael Blow aged 70 years old. The investigation concluded at the end of the inquest on 4 August 2016 and I recorded a conclusion of Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** Michael Blow was admitted to Queen Alexandra Hospital (QAH) on Saturday 27th February just after midnight after falling backwards downstairs at home. In the initial emergency survey he was assessed that he may have an injury to his left shoulder and left chest wall as he was complaining of difficulty in breathing. It was known that he had a history of heart failure and an aortic valve repair & replacement requiring warfarin treatment. His wife told A&E staff that Mr Blow also had COPD and a suspected chest infection so had been commenced on Doxycycline on Wednesday 24th as recommended by the Bronchiectasis Specialist Nurse at QAH. She also confirmed that Michael's INR had been checked on Thursday 25th by the warfarin clinic at QAH with a reading of 4.8 against a target of 3-4. As a result, his dose was reduced on Friday 26th and his last dose was taken at home at approx. 6pm. A chest x-ray confirmed lung contusions and a pneumothorax which required the insertion of a left chest drain. This was to drain air but not blood as the drain was clear at this stage. He was also given 2 units of blood on a preventative basis. A few hours later a chest/abdomen/pelvis CT scan confirmed fractures to the left clavicle and left ribs. As part of the admission protocol his INR was checked and found to be 5.5. Octaplex 1550 units was given after haematology advice to reverse his high INR. Coupled with the blood transfusion, the Octaplex would have had the effect of quickly reducing his INR level.

	Later the same day, Mr Blow was seen by [redacted], a consultant surgeon, for review who as part of the care plan requested another INR check. This basic test was not carried out and, in addition, at some point during Saturday, he was also given 2.5 mg of warfarin. Thereafter appropriate medical attention was given including physiotherapy and pain relief and on Saturday as well as Sunday Mr Blow appeared stable. However, in the early hours of Monday 29th February his condition deteriorated with a suspected further collapse of his lung or contusions to the lung along with a kidney injury. The chest drain now contained blood. His INR at this stage was 9. Eventually Mr Blow went into cardiac arrest and died at 4.40a.m. The cause of death was 1a) Haemothorax; 1b) Fractured ribs and treatment with warfarin; 2) Ischaemic heart disease, hypertension, COPD and pneumonia. The post mortem noted a large (2 litre) haematoma in the left chest.
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. The INR test requested by [redacted] during the morning of Saturday 27th was never carried out despite this being a basic check to baseline Mr Blow's INR levels and see what effect the Octaplex and blood transfusion plus any antibiotic treatment since admission may have had on his reading to inform further treatment. 2. Warfarin was restarted after [redacted] review but was based on an outdated INR reading of 5.5 taken on admission and no account was taken of the Octaplex and blood transfusion plus any other medication such as antibiotics. 3. The clinical evidence heard at the inquest suggests that there is a need to highlight the relevant protocol to junior doctors and nurse practitioners and clarify when to reverse the protocol; who is responsible for this sort of clinical decision; and, importantly when to restart normal warfarin treatment.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th September 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: [redacted]



	I have also sent it to [redacted], Consultant Colorectal Surgeon who may find it useful or of interest. 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	**Date: 12th August 2016** Karen Harrold Karen Harrold Assistant Coroner Portsmouth & South East Hampshire