Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Sir Andrew Dillon Chief Executive National Institute for Health and Care Excellence 10 Spring Gardens London SW1A 2BU Martin Kuper Medical Director Homerton University Hospital Homerton Row London E9 6SR
	CORONER I am: Assistant Coroner Sarah Bourke Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
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 19 September 2017, I commenced an investigation into the death of Georgia Polydorou who was born on 12 July 1937. The investigation concluded at the

	end of the inquest, which was conducted by me on 29 January and 6 March 2018. The conclusion of the inquest was a narrative conclusion. I recorded a medical cause of death of: 1a ventilator associated bronchopneumonia 1b subdural haematoma (operated 11.7.2017) 1c fall 2 mitral valve regurgitation, atrial fibrillation, hypertension, congestive cardiac failure and Beta trait thalassaemia.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Polydorou was an in-patient at Homerton University Hospital due to an exacerbation of congestive cardiac failure. She was recognised to be at increased risk of falls. She was prescribed aspirin, clopidogrel and enoxaparin during her admission. In the early hours of 10 July 2017, Mrs Polydorou fell whilst going to the toilet. She was reviewed by the on call doctor and subject to neurological review every 15 minutes for the first hour and hourly observations thereafter. Her Glasgow Coma Score following the fall was 15/15. It was decided that a CT scan would be undertaken if Mrs Polydorou showed signs of deterioration such as headache, bleeding, dizziness or vomiting. Later in the day, she was reviewed by a junior doctor. As she had had 10 sets of normal neurological observations, a decision was made to revert to standard nursing observations. Mrs Polydorou told family members that she had a headache but she did not mention this to hospital staff. At 6.40 am on 11 July, a nurse went to take Mrs Polydorou's observations and found her unresponsive but breathing. An urgent CT scan showed a large right sided acute subdural haematoma. Mrs Polydorou was transferred to the Royal London Hospital where she underwent an immediate right mini craniotomy and evacuation of the acute subdural haematoma. Her recovery was extremely slow. Mrs Polydorou remained on a ventilator in the Intensive Care Unit for several weeks. During which time, she had multiple episodes of ventilator-associated pneumonia, which were treated with antibiotics. Mrs Polydorou died at the Royal London Hospital on 18 September 2017. The Homerton University Hospital has revised its procedures regarding anti-coagulation and falls as a result of Mrs Polydorou's death.
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 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) Mrs Polydorou did not receive a CT scan within 8 hours of her fall because she had a Glasgow Coma Scale of 15/15, she did not have any abnormal neurological observations and was not taking Warfarin. Mrs Polydorou was concurrently taking aspirin, clopidogrel and enoxaparin

	during her hospital admission. All of which have the effect of thinning the blood. (2) Evidence from a consultant neurosurgeon established that there can be a significant delay in elderly patients showing signs of head injury following a fall, particularly where they are taking blood thinning medications. (3) Mrs Polydorou's first language was Greek. Witnesses described her ability to converse in English as "basic". Whilst in A&E, her son acted as an interpreter in order to obtain a reliable history. Following the fall, it was decided that Mrs Polydorou would have a CT scan if she showed signs of deterioration such as headache, bleeding, dizziness or vomiting. Mrs Polydorou's son, [redacted] was told that his mother had fallen but was not told of the symptoms that may indicate that her condition was deteriorating. During a visit on 10 July, Mrs Polydorou told her son that she had a headache but he did not realise the potential significance of this. Mrs Polydorou did not report her headache to medical staff.
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 10 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 following: • HHJ Mark Lucraft QC, the Chief Coroner of England and Wales • [redacted] son of Mrs Polydorou 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	H.M. CORONER NORTH LONDON **Sarah Bourke** **Assistant Coroner**