REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Maggie Oldham, Chief Executive, Isle of Wight NHS Trust.** **2. Clinical Commissioning Group, Isle of Wight NHS Trust.**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 8th March 2017 I commenced an investigation into the death of Cuthbert Anthony Stanley Hingert, aged 86. The investigation concluded at the end of the inquest on 22nd June 2018. The conclusion of the inquest was Mr Hingert died as the result of an accident. The medical cause of death was found to be: 1a Acute on Chronic Subdural Haematoma. 1b Trauma to the Head. 1c II Heart Failure, Urinary Tract Infection, Chronic Kidney Disease, Hypertension, Atrial Fibrillation treated with Anticoagulant Medication and Diabetes Mellitus.
4	**CIRCUMSTANCES OF THE DEATH** 1) Cuthbert Anthony Stanley Hingert was born on 3rd May 1930 in Ceylon, now known as Sri Lanka. At the time of his death, he was 86 years of age. 2) He was admitted to the Emergency Department of St Mary's Hospital, Isle of Wight NHS Trust, in the morning of the 3rd March 2017 with shortness of breath over the previous 2 weeks. He was found to have pulmonary oedema and preliminary investigations raised the possibility of acute coronary syndrome which necessitated the administration of antiplatelet and anticoagulant medications. During Mr Hingert's management, duplicate doses of these

	medications were given within a short period of time. 3) Mr Hingert was transferred to the Acute Coronary Care Unit (CCU Acute) on the evening of the 3rd March for further management of his Acute Coronary Syndrome. During the first 36 hours in the CCU Acute, Mr Hingert continued to have cardiac symptoms as well as developing symptoms of confusion and reduced mental acuity. 4) On the 5th March 2017, whilst self-mobilising, Mr Hingert sustained a fall hitting his head on the floor. A CT scan showed that he had sustained a subdural haematoma, skull fracture and a subarachnoid haemorrhage. He deteriorated throughout the day and died at St Mary's Hospital, IOW NHS Trust, on the evening of 5th March 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. The evidence revealed that the Medical Registrar did not check the JAC medicines database to see that Mr Hingert had already been administered a stat dose of antiplatelets and anticoagulant medication before prescribing second dose of these medications. 2. The Medical Registrar prescribed aspirin to continue at 300mg rather than at the standard dose of 75mg daily. 3. Mr Hingert had already been prescribed continuing doses of Fondaparinux and Ticagrelor, which (fortuitously) were not administered. 4. There was evidence that at least one of the clinicians treating Mr Hingert had not been trained to use the JAC medicines database. 5. There was a 2-hour delay in writing up a verbal order with regard to a prescribing decision. 6. A decision was made to treat Mr Hingert, who was already confused, with the hypnotic Zopiclone, which may not have been a sound clinical decision. 7. Upon discovering the errors with the medications which are documented above, a nurse did not follow hospital protocol and make a DATIX incident report

	despite acknowledging that she should have done so immediately.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 26th September 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: the family of Cuthbert Anthony Stanley Hingert (and their legal representative, [redacted]) and the Isle of Wight 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	 **H.M. Senior Coroner – Isle of Wight** **1st August 2018**