[redacted]
National Medical Director
Skipton House
80 London Road
SE1 6LH

Miss Emma Serrano, HM Assistant Coroner
Coroners Court
St Katherine's House
St Mary's Wharf
Mansfield Road
Derby
DE1 3TQ

14th January 2021

Dear Miss Serrano

Re: Regulation 28 Report to Prevent Future Deaths – Edward Cowey

Thank you for your Regulation 28 Report dated 14th October 2020, concerning the death of Edward Cowey on 28th January 2020. Firstly, I would like to express my deep condolences to Edward's family.

The regulation 28 report concludes Edward Cowey's death was a result of 1a) Subdural haematoma; II) Anticoagulation.

Following the inquest, you raised concerns in your Regulation 28 Report to NHS England and other involved parties, regarding:

1. That patient electronic and paper-based transfer information is not kept on one database. Edward Coweys' handover notes were kept on extra Med, his neurological observations on Patient Track and the falls form on his hard copy notes;
2. Trust local policy regarding treatment for head injures is not consistent with NICE Guidelines and doctors cannot be expected to be aware of all trust local policies;
3. Anticoagulation guideless do not cover a situation where anticoagulation is being given as a preventative measure as opposed to a treatment; and
4. The Trusts local falls form does not direct doctors to the relevant guidance regarding head injuries simply asks if a CT head scans indicated

You also suggested the following action;

1. You may wish to consider the NHS policy and procedures for patient transfer, anticoagulation and head injury.

University Hospitals of Derby and Burton undertook a Serious Incident investigation into the incident, a copy of the investigation report is also included.

Background

The patient was admitted to the Emergency Department (ED) at the Royal Derby Hospital on 22.1.20 at 11.06am. The history was that he had been generally unwell with shortness of breath and not sleeping. 2 days prior to admission he had been seen by the renal team and his Furosemide had been stopped. He was previously known to the renal team with declining renal function for 5 years.

He had co-morbidities of Angina, Anxiety, Asthma, Type 2 Diabetes, Hypertension, Myocardial Infarction, CVA with slight left sided weakness, Depression and Pneumonia.

After assessment in the ED he was transferred to the Medical Assessment Unit (MAU) at 14.48.

The incident

During his stay at the hospital he suffered 2 falls. The first was on 22.1.20 at 23.55. He was found sitting on the floor and had not sustained any serious injury apart from a bang to the elbow.

The second fall was on 23.1.20 at 03.10. He was mobilising to the toilet whilst being assisted by a Health Care Assistant (HCA) at the time. On this occasion he hit his head on the corner of a wall sustaining a head injury. There was however no loss of consciousness.

He had a medical review and was commenced on neurological observations. He did not have a CT scan as the criteria for CT scan under NICE guidelines was not met.

The outcome

The patient was transferred to ward [redacted] on the 23.1.20 at 12.30pm. At that time, he was asymptomatic and mobile.

He was reviewed by a junior doctor at 16.13pm because he was complaining of numbness in the hands and weakness. These symptoms were attributed to his previous stroke.

A Consultant Physician reviewed the patient at 10.30am the following day, 24.1.20 and the symptoms of left sided weakness was noted.

The patient continued to be independent until the 25.1.20 when he suffered an unresponsive episode. A CT head scan confirmed a large right sided subdural haemorrhage.

A neurosurgical opinion was obtained, (from the Queens Medical Centre, Nottingham) which was that the patient had sustained an acute on chronic subdural haematoma and that he would not survive any surgical intervention.

Sadly, the patient passed away at 18.30 on 28.1.20.

The University Hospitals of Derby and Burton's serious incident investigation into the incident identified the following conclusions:

- Even though robust measures were taken to reduce the patient's risk of falls the patient declined to comply with these. The patient was assessed as having capacity to make his own decision.
- Although the first fall was treated as such there is evidence that the patient had not fallen from his bed to the floor as there was no sign that he had been using his bed at the time.
- He was accompanied by an HCA during the second fall.
- The patient had declined to use bed side toilet facilities and was walking to the bathroom at the time.
- The patient was transferred to ward [redacted] on 23.1.20, whilst the electronic handover was updated to include the fall the nursing staff in MAU did not contact the ward to inform them, therefore some of the neurological observations were missed.
- When the junior doctor assessed the patient on 23.1.20 with symptoms of weakness and numbness the focus was on the previous stroke as the cause rather than the fall.
- However, had the patient had an earlier CT scan the consultants at the review meeting believed that had an earlier discussion with the neurosurgeons at Queens Medical Centre Nottingham taken place, the advice would have been to continue with observations and re-scan should he deteriorate.
- It was the opinion of the consultants at the review meeting that the deterioration of the patient was sudden and unpredictable. Therefore, even if the bleed had been detected earlier and the patient had been on regular neurological observations, the deterioration could not have been prevented and the outcome would have been the same.
- Following the second fall (where the head injury occurred) the doctor who assessed the patient did not request a CT scan. The doctor was following NICE guidance (which only advises a CT scan in symptomatic patients), but the Trust have a separate policy that all head injuries should be referred for a CT scan. However as already discussed, had the patient had an earlier scan the outcome would have been unlikely to have been different as the patient deteriorated rapidly and unpredictably.
- The patient had been prescribed anticoagulation to prevent venous thromboembolism. However, the patient had been prescribed [redacted] of Enoxaparin whereas the dose for a patient with kidney disease should have been [redacted].
- The patient received 3 dose of Enoxaparin [redacted] on 22.1.20, 23.1.20 and 24.1.20. Despite being reviewed by 2 consultants on 23.1.20 and 24.1.20 this was not amended.
- A middle grade doctor noticed the wrong dose on 25.1.20 and change it accordingly. However, the medication was stopped later than day when it was identified that he had suffered from a subdural bleed.
- In the medical review meeting it was noted that whilst anticoagulation is a risk factor for intracranial bleeds following a head injury, the medication that the patient was receiving was not anticoagulation but prophylactic. It was further noted that there is no specific recommendation in the Trusts falls guidelines

that states that VTE (venous thromboembolism) prophylaxis should be stopped following a head injury. Prophylactic Enoxaparin is sometimes given to patients with established chronic subdural haematomas but not with acute bleeds.

- The patient was on 12 different medications. Whilst it is likely that because of his various co-morbidities he required these, it is worth noting that several of these have the side effect of dropping blood pressure and therefore increasing the risk of falls. Polypharmacy 'per sey' increases the risk of falls in the elderly.

Following the serious incident investigation, it has resulted in the following recommended actions by University Hospitals of Derby and Burton NHS Trust:

- The Trust have made changes to how the electronic records are viewed. Staffs are now advised to select the 'my view' page when accessing a patient's records and recording a patient's observations post transfer. Furthermore, the Trust are going to explore having 'my view' as the default screen log on.
- The Trust have tightened up their Standard Operating Procedure (SOP) for ward transfer and VTE status.
- The Trust also concludes that all patients at risk of falls should have a medication review (to edit any medication that may increase risk) and a lying and standing blood pressure to look for postural hypotension. Unfortunately, neither of these were done.
- Communication has been sent out to all staff about patients over 65 years of age having sitting and standing blood pressure on admission.
- MAU are to incorporate the Head injury guidelines and falls policy as part of the monthly training.
- The Senior Sister on MAU will have a discussion with the Senior Sister on ward [redacted], to find a way to improve communication between the wards if such a situation happens again.
- The senior sisters on MAU are working towards being 100% compliant with falls prevention training
- The Trust should urgently review whether its Falls proforma should:
    - Explicitly state when a CT scan of the head should be done, rather than asking, "Is a CT head indicated?"
    - Include a section for post-fall Neurological examination
    - A section on Anticoagulation
    - Explicitly identify itself as a medical document, to be filed in the patient's notes in chronological order
    - The Trust Falls group to urgently discuss the present post-Fall proforma with regard to the points raised, and include a doctor as part of the team doing the review.
- Since this incident occurred there is now a designated doctor on [redacted] who checks all ISBAR handovers, medications and the VTE status of patients
- Staff on MAU will receive communication and training with regard to updating the electronic handovers if additions are made once patients have been referred
- Staff on Ward [redacted] will receive communication and training with regard to revisiting the electronic handover for patients who have been referred but delayed in being transferred to the Ward

- Nursing staff on [redacted] will receive education from the senior members of the team regarding countersigning entries made by student nurses into the nursing and medical notes
- Regarding the use of anticoagulation in either a prophylactic or treatment regimen the Trust refer to NICE guidance which states the following:

Patients having anticoagulant treatment

1.4.12 For patients (adults and children) who have sustained a head injury with no other indications for a CT head scan and who are having anticoagulant treatment, perform a CT head scan within 8 hours of the injury. A provisional written radiology report should be made available within 1 hour of the scan being performed. (For advice on reversal of warfarin anticoagulation in people with suspected traumatic intracranial haemorrhage, see the NICE guideline on blood transfusion.) **[2014, amended 2019]**

- Dr [redacted], The Trusts Medical Director (Quality and Safety) Consultant in Emergency Medicine has contacted NICE to clarify the aspect of the guidance that refers to patients receiving anticoagulation. NICE are clear that any patient whether receiving low-molecular weight heparin for prophylactic or therapeutic reasons are included in this guidance. Consequently, the Trust will be explicit about this in the UHBD guidance. The Trusts Medical Director has also suggested to NICE that CG176 is updated to reflect this advice.
- The learning from this death with be shared at the Reg 28 National meeting so that lessons learnt can be disseminated to other Regions.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

National Medical Director
NHS England and NHS Improvement