University Hospital Southampton NHS
NHS Foundation Trust

Chief Medical Officer
Trust HQ
C Level, Centre Block, Mailpoint 14
Southampton General Hospital
Tremona Road
Southampton, SO16 6YD
[redacted]

24th November 2022

Dear Mr Simpson,

Please find below our response to your Regulation 28: Report to Prevent Future Deaths which you issued on the 8th September 2022, following the inquest into the death of Mr Robert Taylor held on August 5th 2022. I am grateful for your extension for the response til the end of the November 2022.

CIRCUMSTANCES OF THE DEATH
Mr Taylor was admitted to Southampton General Hospital after a fall where he had suffered significant facial fractures and a subdural haematoma. He suffered epistaxis (nosebleed) which was treated with Rapid Rhinos. Subsequently he suddenly deteriorated very quickly, went into cardiac arrest and passed away.

Your concerns:

The deceased suffered facial fractures and had episodes of epistaxis. I heard evidence that when a clot forms within the nose the bleeding can continue and is only visible if the back of the patient's throat is looked at. I heard evidence that, in the Emergency Department and Trauma Admission Unit, the importance of checking the back of the throat of a patient with a history of epistaxis or facial fractures was not widely known.

Our response:

Firstly, I would like to reassure you that the Trust is committed to ensuring that our patients are safe at all times, and I thank you for raising your concerns with us to investigate.

In order to review the issues you raised, I chaired a meeting with representatives from ENT, T&O and the Emergency Department, including nursing, medical and surgical staff. Additionally, this case has been discussed at the ENT Morbidity and Mortality meeting on 10th November.

Mr Taylor was admitted with a number of injuries, including a head injury and a number of facial fractures. He had a history of heart attacks that would have left him with significantly reduced physiological reserve. Mr Taylor also had a low haemoglobin count on admission of 86g/l (where a normal would be considered 120-150 g/l). Bleeding in facial trauma is extremely common. On the CT scan from admission, it is reported that

"there are comminuted nasal bone fractures which results in hyperdense opacification of the right paranasal sinuses, consistent with haematoma. This can be seen extending into the nasopharynx".

At the initial meeting, as well as the concerns you raised, I examined whether the Trauma Assessment Unit (TAU) was the appropriate ward for Mr Taylor to have been placed. In a complex trauma case such as his, the head injury was the primary concern, and as Mr Taylor was not considered a major trauma patient and did not clinically warrant placement on either the high dependency or intensive care unit and that his placement on the TAU was appropriate.

We reviewed the national guidance available for the management of epistaxis, currently the only guidance is from NICE (https://cks.nice.org.uk/topics/epistaxis-nosebleeds/management/acute-epistaxis/) this is for when epistaxis have started spontaneously and is not applicable for Traumatic injury such as the case of Mr Taylor. This highlights that there are no national guidelines that suggest the review of the back of a patient throat is advised.

I explored whether your suggestion of inspection of the back of the throat needed to be built into our existing pathway. We agreed that this was not believed to be of great clinical value, nor in line with national guidance however this was explored further by the ENT team as part of their morbidity and mortality group.

Following their M&M meeting the opinion of the ENT team was that the significant bleeding had occurred prior to the placement of the rapid rhino packing, and it is likely that the clot had formed, and been oozing from about 8pm on the previous evening. It was considered that Mr Taylor suffered an atypical posterior epistaxis post trauma. Anecdotally, awake patients are normally aware of the trickle of blood to the back of the throat, not least because it is uncomfortable and is very unpleasant in taste. It is unusual for patients not to spit this out.

The actions that I support coming out of my discussion with the team is that the clinicians treating such patients would build into their education programme that patients should be explicitly asked to report an unpleasant taste or sensation. Following the meeting I chaired, the following was disseminated to all ENT, OMFS (oral-maxilla facial surgeons) and the cross covering senior house officers.

"I've been asked to highlight some learning from an incident on an outlying ward involving a patient with epistaxis after facial trauma.

Please could I remind all SHOs managing epistaxis and facial trauma patients to counsel their patients and nursing staff to look out for any continuing epistaxis either anteriorly or posteriorly. This is particularly important after nasal packing has been used to ensure the bleeding has stopped. If there is any doubt, then please consider returning after a reasonable timeframe to examine the oropharynx and ensure there is no further fresh bleeding."

The case was discussed at the ENT M&M meeting on 10th November 2022. The department were content that the management by the SHO was clinically appropriate. It was clearly documented that the posterior bleeding, once identified, stopped after the was pack inserted. It was agreed to raise awareness of epistaxis in facial trauma in OMFS and ED teams managing them. Specific guidance to check the oropharynx in these situations has been added to the surgical SHO induction sessions.

I fully appreciate that your recommendations came from witnesses interviewed in the hearing, however, perhaps the witness giving this advice was not the most suitably qualified or experienced person to do so? Whilst this was a qualified doctor, with skills and experience sufficient to cross cover ENT, they had not even completed surgical training and had no specific ENT experience or qualifications. Hence, I have turned to a team of experts to advise me, led by an experienced consultant not only in ENT but with a specialist interest in rhinology. I hope then that this input is valuable.

In addition to the clinical concerns, I note your comment about the legal team not being in attendance. Inquests are managed by the Patient Safety Team at UHS and we do not routinely engage our solicitors for inquests, we aim to attend all inquests with UHS witnesses wherever possible, attendance is prioritised where witnesses have not given evidence previously.

Yours sincerely,

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Chief Medical Officer

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