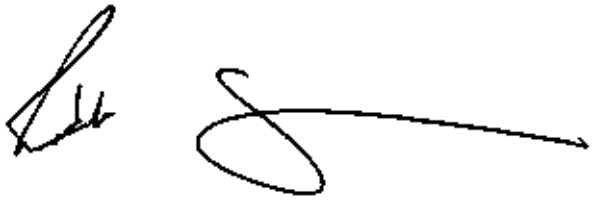
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted] **University Hospital Southampton NHS Foundation Trust**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 16 June 2021 I commenced an investigation into the death of Robert Graham TAYLOR aged 82. The investigation concluded at the end of the inquest on 05 August 2022. The conclusion of the inquest was that: On the 5th June 2021 Robert Graham Taylor died at Southampton General Hospital as a result of blood loss due to an injury incurred when he fell over on the 4th June 2021.
4	**CIRCUMSTANCES OF THE DEATH** Mr Taylor was taken to Southampton General Hospital after a fall where he suffered significant facial fractures and a subdural haematoma. He suffered epistaxis (nose bleed) which was treated with Rapid Rhinos. Subsequently he suddenly deteriorated, went into cardiac arrest and passed away.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 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.
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 November 03, 2022. 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 who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 08/09/2022**  **Robert SIMPSON** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**