MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroners, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 15653789

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted]**Chief Executive, Barts Health, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB** [redacted] • [redacted] **The Secretary of State for Health & Social Care 39 Victoria St, Westminster, London SW1H 0EU** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 19th October 2021 I commenced an investigation into the death of Ghulam Mohammad age 89 years. The investigation concluded at the end of the inquest on 19th April 2022 and 6th October 2022. I made a determination of a narrative conclusion: *Mr Ghulam Mohammad was admitted to hospital on 9th October 2021. Whilst an inpatient he suffered a fall on 11th October 2021, he died as a consequence of injuries sustained in that fall on 18th October 2022.* *Mr Mohammed's medical cause of death was determined as;*

	1a Subdural Haematoma 1b Community Acquired Pneumonia 1c II Chronic Kidney Disease, Type 2 Diabetes Mellitus, Hypertension
4	**CIRCUMSTANCES OF THE DEATH** Ghulam Mohammed was an 89-year-old man admitted to hospital 9/10/21 by ambulance following an unwitnessed fall. On admission his blood results showed; coagulopathy and acute kidney injury. Imaging showed no intra-cranial bleed but was suggestive of pneumonia and faecal impaction. He was treated with IV fluids an anti-biotics. Mr Mohammed was prescribed Vitamin K after discussion with Haematology. On 11/10/21 Mr Mohammed sustained a fall in the bathroom causing a head injury, he became more confused. Following a medical review an urgent CT head was requested. A CT head was not undertaken until 15/10/2021, a four-day delay. Prior to undergoing the CT head – Mr Mohammed was prescribed low molecular weight heparin, a prophylactic against the risk of venous thromboembolism which impedes clotting function. The CT head identified a large right-sided subdural haematoma with a midline shift. Following neurological advice conservative management was given, the patient's condition deteriorated and he sadly passed away on the 18/10/2021.
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. A patient with a high risk of falls sustained a fatal injury in an avoidable fall in hospital. 2. Following that fall, an urgently requested CT head was delayed for four days. 3. Before the requested CT head was undertaken, a doctor prescribed blood thinning medication – enoxaparin to Mr Mohammed. Enoxaparin can exacerbate an intra-cranial bleed. The medication was administered on 13 & 14th October 2021. Both the prescription and the administrations of enoxaparin were made without knowing the extent of any intra-cranial damage caused by the fall on 11/10/21. 4. Inadequate record keeping meant that there was no contemporary account of the factors taken into consideration by the doctor or her supervising consultant in prescribing enoxaparin. 5. Neither the Trust's initial SI investigation nor the consultant statement to the inquest mentioned the use of enoxaparin or the lack of clinical records justifying its use.
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 **9th January 2023.** 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 Mr Mohammad, the General Medical Council and the CQC. I have also sent it to the local Director of Public Health 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 other 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.
9	**[DATE] 14/11/2022 [SIGNED BY CORONER]**