REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The National Institute for Health and Care Excellence** **2nd Floor, 2 Redman Place** **London** **E20 1JQ** **nice@nice.org.uk**
1	**CORONER** I am Samantha Marsh, Acting senior Coroner for the coroner area of Somerset
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 the 26th August 2020 the then-Senior Coroner, Mr Tony Williams, commenced an investigation into the death of Glenn Barton, aged 71. The investigation concluded at the end of the inquest, heard before me, on the 16th August 2022. The conclusion of the inquest was Accidental death, including medical cause of death being Ia) Traumatic subdural haematoma II) Myelodysplasia (Chronic Myelomonocytic Leukaemia) With a finding in box 3 that: On the 19th August 2020, Glen BARTON tripped on garden steps at his home address consequently falling and striking his head on the door of the garage. Glen had an existing diagnosis of myelodysplasia (chronic myelomonocytic leukaemia). This meant he had a low platelet count which is a form of blood clotting disorder. The day after this fall, on the 20th August 2020 Glen drove himself to the Minor Injuries Unit at Bridgwater hospital where he was triaged by a trainee emergency nurse practitioner and assessed by an emergency care practitioner in accordance with NICE guidelines. As part of this assessment there was a telephone discussion with a staff grade clinician at Musgrove Park Hospital. Glen was then discharged home with written and verbal head injury advice as at that time he did not present with any clinical features that would indicate a CT

	scan was required. It was not appreciated at the time of triage nor assessment that a diagnosis of leukaemia may have increased Glen's risk of suffering a significant intracranial bleed following a relatively minor head trauma and the operative clinical guidance was ambiguous on whether a CT scan would be required. On the 21st August 2022 Glen developed severe headaches and vomiting following his fall 2 days previously. He attended Musgrove Park Hospital Emergency Department where a CT scan was requested. This was not performed until 21:50 due to other patients presenting with a more urgent clinical need. There was no record of any neurological observations but nursing staff became concerned about his cognitive abilities. The CT scan revealed a catastrophic subdural haematoma which was unsurvivable. Glen was not a candidate for surgical intervention. He died on the Twenty-second of August 2020 as a result of the subdural haematoma sustained at the time of the original fall. There has been no evidence that an earlier scan would have changed the tragic outcome.
4	**CIRCUMSTANCES OF THE DEATH** Glenn had his left arm amputated when he was 17, back in 1966. He was diagnosed with myelodysplasia (chronic myelomonocytic leukaemia) on the 31st December 2019, following a bone marrow biopsy. On the 19th August 2020 Glenn suffered a mechanical fall up some garden steps at his home. Due to only having one arm he wasn't able to fully break his fall, hitting his head on the garage side door and sustaining a graze on his head. He didn't lose consciousness. He elected not to seek medical attention on the day. The following day, 20th August 2020, he attended the Minor Injuries Unit ("MIU") at Bridgwater Community Hospital where the underwent a full and thorough triage at 11.03 by a trainee emergency nurse practitioner who noted his diagnosis of leukaemia. This took place 4 minutes after his arrival. He was then assessed by an emergency care practitioner ("ECP") 20 minutes later who, again, conducted a full and comprehensive neurological assessment. The ECP contacted a Senior Doctor at Musgrove Park Hospital to discuss Glenn, given his diagnosis of Leukaemia. The consensus of medical opinion at the time was that in the absence of any clinical features and/or concerns within the neurological assessment, then Glenn was suitable to be discharged home with appropriate head injury advice. At 18:27 on the 21st August 2020 Glenn attended the Emergency Department at Musgrove Park Hospital with a headache. This is the first time he had experienced that symptom since his fall two days previously. A CT scan was organised which revealed a major brain haemorrhage. Discussions with had with the Neurological Department at Southmead Hospital and Glenn was not a surgical candidate. He died the following day.
5	**<u>CORONER'S CONCERNS</u>** 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. – During the course of the Inquest the evidence revealed matters giving rise a 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. NICE Guidance (Head Injury: assessment and early management published January 2014) states at para 1.4.12 that only patients who are on anticoagulant treatment should be offered/given a CT scan following a head injury with no other symptoms of concern (i.e. no loss of conscious, vomiting and no reduced CGS). It was clear from the evidence that there are other naturally occurring conditions, such as leukaemia, which can affect the ability of a patient's blood to clot and so it would place such patients in the same potential risk category as those on anticoagulants, yet it is clear that a distinction is made. Consequently I am concerned that the guidance (that for the avoidance of doubt was followed during Glenn's treatment) is ambiguous for such patients in terms of triage and a treatment/investigatory path meaning that there may be missed opportunities to CT scan patients in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you your organisation has 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 **18th October 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: (i) [redacted] (Glenn's wife); and (ii) Somerset Foundation Trust 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	**30th August 2022**