North West Kent Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE
[redacted]

Date: 19 December 2023
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Executive, Gravesham Borough Council.

The Chief Coroner, [redacted]

1. CORONER

I am Alan Blunsdon Assistant Coroner for North West Kent.

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 6 October 2023 I commenced an investigation into the death of Richard HEDGES. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Accident

1a Hypoxic Brain Injury

1b Out of Hospital Cardiac Arrest

1c Fall with Traumatic Cervical Spine Fracture

II Chronic Obstructive Pulmonary Disease, Previous Pulmonary Embolism

4. CIRCUMSTANCES OF THE DEATH

Mr Hedges was admitted to the critical care unit following an unwitnessed fall at his residence.

He fell in some short stairs leading to a bin, and was found at the bottom of the stairs with his head down, already looking hypoxic was unresponsive, and a pulse was not detectable.
Immediate cardio-pulmonary resuscitation (CPR) was started by a grand-daughter.
London Ambulance service arrived and confirmed PEA arrest; further 22 minutes of CPR to obtain ROSC.
An iGel was inserted for ventilation.
Initially Mr Hedges was very unstable, requiring Adrenaline infusion to maintain blood pressure.
On arrival to A&E Mr Hedges was intubated and ventilated.
Trauma CT scan revealed an unstable C6 and C7 fracture and bilateral rib fractures (no flail segment).The spine was immobilized and the fracture managed conservatively.
The initial CT head showed no signs of intracranial injury except for a superficial haematoma on the scalp.
A superficial laceration was sutured in A&E.
Mr Hedges was admitted to critical care and stabilised.
He was neuro-protected for 48 hours, with full sedation.
Initial haemodynamic instability resolved, and he was almost off Noradrenaline.
Sedation (Propofol and Fentanyl) was stopped on 24/09 in the morning, but Mr Hedges remained with a GCS E1VtM1, and absent reflexes on triggering of the ventilator.
A repeat head CT head was done at 72 hours of admission; this revealed widespread hypoxic brain damage with bilateral uncal herniation, crowding of the foramen magnum, and bilateral extensive infarcts.
The overall outcome looked very poor given the prolonged out of hospital cardiac arrest, extensive hypoxic brain injury with uncal herniation and no improvement in neurology.
A decision was made to move to comfort care and extubate Mr Hedges, after discussions with the family members. The family mentioned multiple times that Mr Hedges had been deteriorating over the last 6 months prior to admission.
He was having memory problems, and had some panic attacks (long-standing problems).
Mr Hedges sadly passed away on 26/09/23 @ 15:48

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 will 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)The short external staircase where Mr Hedges fell is constructed of concrete steps which are showing signs of wear/weathering. The steps are not coated with a non slip surface and the edges of the steps do not have highlighting to increase awareness.

(2)The handrail for use with the steps appears too short at each end and reduces the available support to users of the steps

(3) The current lighting of the area of the external staircase is poor.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the Chief Executive 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 14TH February 2024 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 am also under a duty to send the Chief Coroner a copy of your response.

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.

19 December 2023

Signature 

Alan Blunsdon Assistant Coroner for North West Kent