REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive Office, National Institute for Health and Care Excellence, 10, Spring gardens, London SW1A 2BU**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 21st February 2013 I commenced an investigation into the death of Selina Isabella Broadhurst dob 1st January 1927. The investigation concluded on the12th February 2014 and the conclusion was one of Accidental Death. The medical cause of death was 1a Bronchopneumonia 1b Intra-cerebral Haemorrhage and 2 Vascular dementia and Type two diabetes mellitus.
4	**CIRCUMSTANCES OF THE DEATH:** On the 14th February 2013 she fell at the E.P.H. where she lived and suffered a blow to the head. She was admitted to hospital and, inter alia, she was not afforded a CT scan of her head until a second admission some hours later when she was shown to have a major bleed to the brain. This was despite the fact that she had an external injury to the front of her scalp.
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. The Emergency Department doctors indicated that they could not get a CT of the head because "the NICE Guidelines do not indicate as being appropriate where there are no obvious neurological signs". I have noted in this inquest and indeed in a number of inquests previously that the doctors are following these guidelines and in fact many severe brain injury cases are being missed or there is a delay in diagnosis. Is it not now time that this guideline was re-examined and the advice amended, especially when dealing with the very frail elderly patient?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have

	the power to take such action. It is essential that full information is passed promptly to the GP practice of a patient being discharged.
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 April 2014. 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 namely [redacted] (daughter of the deceased) and the Chief Executive of the Tameside Hospital NHS Foundation Trust. 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.
9	**17th January 2014** **John Pollard, HM Senior Coroner**