REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT is being sent to: **Mr Simon STEVENS** **Chief Executive** **NHS England** **PO Box 16738** **REDDITCH** **B97 9PT**
1	**CORONER** I am **Mr Tom OSBORNE,** Senior Coroner for the Coroner Area of Bedfordshire and Luton.
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 22nd November 2012 I commenced an Investigation into the death of **Nicola Valerie MARSDEN** aged 35 years. The Investigation concluded at the end of the Inquest on 13th March 2014, where I brought in a Narrative Conclusion, the medical cause of death being: I (a) Raised Intracranial Pressure (b) Cerebral Haemorrhage
4	**CIRCUMSTANCES OF THE DEATH** On the 14th November 2012 **Nicola Valerie MARSDEN** gave birth to her son at Bedford Hospital. Prior to, and immediately after the baby was delivered by Caesarean Section, she developed worrying neurological symptoms. An MRI Scan was carried out but was mis-interpreted and failed to recognise an haemorrhagic infarct. The serious nature of her condition was not recognised and this resulted in a lost opportunity to treat her appropriately and she died of a raised intracranial pressure due

	to a cerebral haemorrhage on 17th November 2012.
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: • That during the course of the evidence I was told that the brain scan relating to the deceased was mis-interpreted. The CT scans were viewed by a Radiologist and not a Neuro-Radiologist, despite the fact that there is a Guideline for having the scans viewed by a Neuro-Radiologist at Addenbrooke's Hospital. • My concern is that the interpretation of neurological scans and brain scans should be viewed and reported by Neuro-Radiologists and perhaps the Protocol for viewing of scans by non-specialists should be reviewed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of NHS England, 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 October 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 Person(s):

[redacted] **- husband**

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 **Dated this 14th day of August 2014**

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Tom OSBORNE
Senior Coroner
Bedfordshire & Luton

H.M. CORONER BEDFORDSHIRE AND LUTON