IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Marie Gretta Harding
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **NHS England**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 17/10/14 I opened an inquest into the death of **Marie Gretta Harding** who, at the date of her death was aged 63 years old. The inquest was resumed and concluded on 10/4/14 I found that the cause of death to be: - 1a. Chest drain insertion (inserted 12.10.14) 1b Pneumothorax 1c Emphysema I concluded by way of a narrative as follows: On 14/10/14 Marie Gretta Harding died from a known complication of a necessary elected therapeutic procedure.
4	**CIRCUMSTANCES OF THE DEATH** On 6/10/14 Marie Gretta Harding, who had a history of chronic obstructive pulmonary disease was admitted to Bradford Royal Infirmary suffering from breathlessness, where she was found to have suffered a left sided pneumothorax necessitating a chest drain. Subsequently, on 12/10/14, a further chest drain was inserted which more likely than not penetrated her left lung and she deteriorated and died on 14/10/14.

5	**CORONER'S CONCERNS** During the course of the inquest I heard that their was no trust guidelines for the insertion of chest drains, lack of up to date training on chest drain insertion and an unawareness of the existence of the on call weekend availability of interventional radiologist. Although I acknowledge that the Trust has now fully instigated remedial changes in this regard; The **MATTER OF CONCERN** is as follows. – • To review the national guidelines for the insertion of chest drains to ensure lessons learnt by all NHS Trusts in England and Wales
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that NHS England has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: • [redacted] • Bradford Teaching Hospitals NHS Trust • Chief Coroner
9	**DATED this 12 June 2015**