REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Heart of England NHS Foundation trust** **2. NHS England**
1	**CORONER** I am Louise Hunt, senior coroner, for the coroner area of Birmingham and Solihull
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 08/06/15 I commenced an investigation into the death of Adrian Mark Smith. The investigation concluded at the end of the inquest on 14/10/15. The conclusion of the inquest was the deceased died from a complication of heparin treatment which was given for a sagittal sinus thrombosis.
4	**CIRCUMSTANCES OF THE DEATH** The deceased attended A&E at Good Hope hospital on 31/05/15 having suffered a seizure at home. He was discharged home with antibiotics for a chest infection. He was admitted to Good Hope Hospital on 03/06/15 complaining of a headache, left shoulder pain and a fever. Again a chest infection was suspected as the cause for his symptoms. At 08.00 on 04/06/15 he was found fitting on the floor. A CT scan undertaken at 10.36 confirmed a bilateral frontal haemorrhage of the brain. There was discussion with the Queen Elizabeth Hospital neurosurgical department who recommended a MRI scan with DWI and ADC. The radiologist at Good Hope hospital said this test was not warranted and it was never undertaken. The evidence heard at the inquest from a Professor of Neurosurgery at Queen Elizabeth hospital was that this test was indicated and would have diagnosed the sagittal sinus thrombosis. At 16.41 on 05/06/15 a CT scan with contrast was undertaken which diagnosed the sagittal sinus thrombosis. There was discussion with the Queen Elizabeth neurology department who advised treatment with heparin. At 04.30 on 06/06/15 the deceased collapsed. A CT scan confirmed a further brain bleed. He was transferred to Queen Elizabeth hospital where a decompression operation was undertaken. He failed to improve and passed away on 08/06/15.
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) Clear instruction was given by the Queen Elizabeth hospital to undertake an MRI scan to confirm the possible diagnosis. This instruction was not followed by the staff at Good Hope Hospital. Systems need to be put in place to ensure that specialist advice is followed.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe your organisation 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 11th December 2015. 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 family. 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	**16th October 2015**