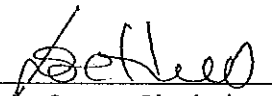
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sandwell and West Birmingham NHS Trust** **2. University Hospital Birmingham NHS foundation Trust**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this 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 10/12/2015 I commenced an investigation into the death of Leslie William Carswell. The investigation concluded at the end of the inquest 19th April 2016. The conclusion of the inquest was that the deceased died from a brain bleed following a fall. There was a delay in reviewing the CT scan and administering beriplex more quickly which contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to D7 at City Hospital on 18/11/15 following a transcatheter aortic valve implementation at New Cross Hospital. He was transferred to ward D47 on 22/11/15 for rehabilitation. He was assessed to be at high risk of falls. He was seen regularly by physiotherapists and assessed to be improving. He had capacity and was informed to use his call bell when mobilising. At 19.25 on 29/11/15 the deceased was found face down on the floor having been to use the toilet. He was taken to Sandwell hospital emergency department, as per protocol, where a CT scan at 00.50 confirmed bilateral sub-acute on chronic subdural haematoma. A decision was made at 02.30 to give Beriplex to reverse the effects of warfarin however the deceased suffered a further serious bleed at 05.05 before this could be given. He died on the intensive care unit at 12.30 on 30/11/15.
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) There were technical difficulties transmitting the CT scans taken at 00.50 to the Queen Elizabeth Hospital in Birmingham for review which is the protocol for the west midlands. This caused a delay in deciding a treatment plan. I heard evidence at the inquest that these concerns are ongoing and no resolution has been found. There is a concern that patients with urgent conditions could have lifesaving treatment delayed due to technical difficulties between the two trusts.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Sandwell and West Birmingham Hospitals NHS trust 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 15 June 2016 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 have also sent it to NHS England who may find it useful or of interest. 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	19/04/2016 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**