REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Secretary of State for Health**
1	**CORONER** Christopher Dorries, senior coroner for South Yorkshire (West)
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. (1) Where – (a) A senior coroner has been conducting an investigation under this Part into a person's death and (b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
	INVESTIGATION and INQUEST On 30th June 2015 I commenced an investigation into the death of Captain James Michael Bedforth. The investigation concluded at the end of the inquest on 7th September 2016. The conclusion of the inquest was that Captain Bedforth died from *1(a) Cerebral haemorrhage* *1(b) Significant pulmonary embolus and paradoxical embolus to the brain (treated)* *1(c) Deep vein thrombosis (left)* A narrative conclusion was recorded as follows: *Captain James Michael Bedforth died at the Barnsley Hospital on 30th June 2015 in consequence of treatment given to him, in accordance with the hospital protocol, for a pulmonary embolus including a paradoxical embolus to the brain.*

4	**CIRCUMSTANCES OF THE DEATH** Captain Bedforth was a senior long haul airline pilot. Such an occupation obviously involves prolonged seated immobility although there is some opportunity for movement. On the 18th April 2015 he attended the hospital at Barnsley with pains in his left leg around the knee. Appropriate investigations were made (in accordance with NICE guidelines) which included scanning of the upper but not lower leg. Nothing was found and Captain Bedforth was discharged. On 29th June 2015 Captain Bedforth collapsed at his home some hours after a flight from China. He was admitted to the hospital with classical symptoms of a DVT but further collapsed a few hours later and was treated with Alteplase. A CT scan showed pulmonary embolus and an early left sided cerebral infarction due to a paradoxical embolism. Heparin treatment was subsequently given (and stopped at 2235). The Captain deteriorated markedly after a seizure at 2345. A further CT showed an unsurvivable left sided acute cerebral haemorrhage. The inquest found a strong inference that this had arisen from over-anticoagulation with Heparin. Death occurred at 1145 the following morning 30th June 2015.
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 **MATTER OF CONCERN** for the Secretary of State to consider is as follows: The inquest heard that the scanning practice followed after the first attendance was in accordance with NICE guidelines (indeed possibly a little in excess of the guidance) which did not include scanning of the lower leg. This was said to be on the basis that not all lower leg DVTs will be visible. Yet it became apparent that that there is mixed practice on this point, some hospitals clearly consider that lower leg scanning is worthwhile. Hindsight strongly suggested that Captain Bedforth was developing clots in the left lower leg at the time of the first visit. The inquest found that a full leg scan might have provided the hospital with an opportunity to treat Captain Bedforth although it was accepted that no-one could be certain of this. The Secretary of State for Health is asked to consider whether it is appropriate for further research to be conducted as to the question of lower leg scanning. Note that a separate Regulation 28 report is being sent to The Chief Executive at the Hospital in Barnsley relating to 'safety netting' on the first visit, possible delay following the second admission and anti-coagulation practice.
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.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th January 2017. I may extend this period, if asked, particularly given the Christmas break. 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: The family of Captain Bedforth The Chief Executive, Barnsley NHS Foundation Trust The Civil Aviation Authority British Airways The Care Quality Commission 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 at the time of your response, about the release or publication of your response by the Chief Coroner.
9	**18th October 2016** ***Christopher P. Dorries*** **OBE** HM Senior Coroner South Yorkshire (West)