REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive National Institute for Health and Care Excellence (NICE).
1	CORONER I am Christopher Murray, Assistant Coroner, for the coroner area of South Manchester
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 11th April 2018 an investigation into the death of Colin Bailey was commenced and an inquest opened on 19th April 2018. The Inquest was concluded on 19th March 2019 and the conclusion was one of Narrative: Mr Bailey died as a result of a recognised risk of the use of anti-coagulant medication in combination with his co-morbid conditions The medical cause of death was 1a Extensive subarachnoid haemorrhage bilaterally with intraventricular extension of bleed. 1b Hypertension II Ischaemic stroke, atrial fibrillation requiring anti-coagulation, type 2 diabetes.
4	CIRCUMSTANCES OF THE DEATH Mr Bailey was admitted to Stepping Hill Hospital following a stroke on 9th March 2018. He was transferred to Tameside General Hospital on 14th march 2018 to continue his rehabilitation. On 10th April 2018 his condition suddenly deteriorated. A CT scan of the head showed an extensive subarachnoid haemorrhage bilaterally with intraventricular extension of the bleed which was linked to and probably exacerbated by the use of anticoagulant medication. His health worsened and a as result of the subarachnoid haemorrhage he died at Tameside General Hospital

	on 10th April 2018.
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. – The inquest heard that Mr Bailey fell and hit his head whilst an in-patient at Stepping Hill hospital. No CT scan of the brain/head was undertaken despite Mr Bailey taking anti-coagulant medication because NICE guideline recommend a scan is undertaken if the patient has fallen, struck their head and is taking warfarin but that is not the guidance if the anticoagulant medication is one of the other types of anticoagulant medications used. The clinicians attending the Inquest indicated that a CT scan in this scenario should be undertaken whatever the type of anti-coagulant medication and that is the Trust's own policy going forwards. There was concern that this ought to be national guidance.
6	ACTION SHOULD BE TAKEN In my opinion, action should be taken to consider whether the guidance should change 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 26th May 2019. 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 Persons namely [redacted] Family of the deceased. 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	Christopher Murray HM Assistant Coroner 29th March 2019