REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: TAMESIDE GENERAL HOSPITAL
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 18th May 2020 I commenced an investigation into the death of Joseph Brindley. The investigation concluded on the 13th November 2020 and the conclusion was one of Narrative: Died from the consequences of an intracranial bleed, exacerbated by anticoagulation. The medical cause of death was 1a Intracranial bleed on a background of anticoagulation, II Ischaemic Heart Disease, Atrial Fibrillation, Chronic Kidney Disease, Hypothyroidism
4	CIRCUMSTANCES OF THE DEATH On 11th March 2020, Joseph Brindley was admitted to Tameside General Hospital following a fall. He had a significant pleural effusion. He also had rib fractures, which were not identified on a CT scan or in X-rays, although they were visible in two X-rays. He was subsequently discharged from Tameside General Hospital. He was breathless at home and returned to the Emergency Department on a number of occasions and there was a suspected pulmonary embolism identified on one occasion. That was excluded with a CT pulmonary angiogram although the rib fractures were identified at that point. On 16th May 2020, he was found unresponsive downstairs at his home address. On admission to hospital, a CT scan identified a catastrophic bleed to the brain, exacerbated by anticoagulation. He died at Tameside General Hospital on 16th May 2020.
5	<u>CORONER'S CONCERNS</u> 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 the CT scan and the X-rays were said to have been

	examined carefully. However, the fractures were not identified. Availability of radiologists due to a shortage of qualified radiologists locally and nationally meant that radiographers as well as radiologists were involved in the reviews that did not identify the fractures. The final review where the fractures were not picked up was said to have included careful comparison with the earlier X-ray. The Trust have made HMC aware of review processes which seek to enhance clinical skills and avoid errors. However, it is unclear what steps have been taken to tackle and avoid the specific concerns that arose in this case where 3 qualified members of staff did not recognise the injury.
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 14th February 2021. 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], daughter of the deceased, and Tameside General Hospital, 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	Signature of Alison Mutch, HM Senior Coroner 21/12/2020