REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Tameside & Glossop Integrated Care NHS Foundation Trust.
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 30th September 2020, I commenced an investigation into the death of Roger Ballard. The investigation concluded on the 16th April 2021 and the conclusion was one of Narrative: Died from an acute pontine haemorrhage contributed to by the decision to continue with anticoagulation treatment, against the advice of the specialist team to stop it due to the treating clinicians not recognising that a subarachnoid haemorrhage had been identified in the scan of 12th September 2020. The medical cause of death was 1a Acute Pontine Haemorrhage 1b Anticoagulant therapy; II Diabetes, Parkinson's Disease, Atrial fibrillation, Hypertension.
4	CIRCUMSTANCES OF THE DEATH Roger Edward Humphrey Ballard was on anticoagulation medication. He was admitted to Tameside General Hospital on 12th September 2020 with a head injury. A CT scan showed a contusion and a subarachnoid haemorrhage. The advice of the neurological surgeons was conservative treatment and to stop the anticoagulation medication. His anti-coagulation medication was not stopped due to the treating clinician at Tameside General Hospital not recognising there was a subarachnoid haemorrhage on the scan and not following the advice of the neurosurgeons. In the early hours of 15th September 2020, Dr Ballard was readmitted to Tameside General Hospital. A CT scan showed a catastrophic bleed caused by the anticoagulation medication, age and hypertension. He would not have, on the balance of probabilities, have developed the bleed seen on 15th September if the advice to stop the anticoagulation had

	been followed.
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. – 1. The inquest heard evidence that the way in which the scan was reported and then recorded was not clear and contributed to the treating clinician not appreciating the scan findings. 2. The documentation regarding clinical decisions taken including the decision to not follow the advice of the neurosurgeons was not documented in the notes. It was unclear if there was an expectation that where clinicians took a decision contrary to such advice how and in what detail the rationale should be recorded within the notes.
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 19th July 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 the family of the deceased, 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	Date: 24th May 2021 Signature:  Alison Mutch HM Senior Coroner, Manchester South