REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS England
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 10th June 2021 I commenced an investigation into the death of Vilem Bock. The investigation concluded on the 14th February 2022 and the conclusion was one of Narrative: Died from the consequences of anticoagulation given for a week when there was a delay in a CTPA being performed due to arrangements to overcome a language barrier not being made at the time the CTPA was arranged. The medical cause of death was 1a Multiorgan failure ;1b Sepsis; 1c Infected retroperitoneal haematoma following anticoagulation therapy on background of community acquired pneumonia with thrombocytopenia
4	CIRCUMSTANCES OF THE DEATH Vilem Bock had very limited English and needed family support or an interpreter/interpretation service to communicate effectively and to give consent for treatment. He was admitted to Tameside General Hospital and treated for sepsis. On 18th May 2021 it was suspected he had a pulmonary embolism (PE). He was commenced on anticoagulation medication. An inpatient CTPA was arranged for the next day. On 19th May 2021 the CTPA did not take place because no arrangements had been made for an interpreter to be present and the interpretation tool was not utilised. The radiology team decided that necessary checklist could not safely be completed due to this. The scan did not then take place until 25th May 2021. No PE was found when the CTPA was undertaken, and anticoagulation was stopped immediately. On 25th May he had abdominal discomfort and an urgent CT scan on 26th May confirmed a large retroperitoneal haematoma caused by the anticoagulation medication he had been on whilst awaiting the CTPA. He deteriorated as a consequence of the haematoma. He developed new symptoms of sepsis and on 2nd June an infected para-rectal haematoma was identified as the cause of the sepsis. On 4th June he was operated on to try to clear the infection and formation of defunctioning colostomy. He continued to deteriorate post operatively and died at Tameside General Hospital on 6th June 2021.

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 Trust in question has taken steps since the death of Mr Bock to improve the identification of the need for an interpreter to prevent language being a barrier to access to treatment. However, it was unclear from the evidence given that from a national perspective there were protocols in place to ensure that other Trusts would avoid a similar situation arising where language was a barrier to accessing care
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 23/06/2022. 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] (NOK) 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	 Alison Mutch HM Senior Coroner HM Coroner's Court Manchester South