REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Manchester University 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 7th April 2020 I commenced an investigation into the death of Alison Jean Shirley Jeanes. The investigation concluded on the 14th September 2020 and the conclusion was one of **Narrative: Accidental death contributed to by a high INR level from anticoagulation.** The medical cause of death was **1a) Traumatic subdural haemorrhage on a background of anticoagulation; II) Chronic kidney disease, vascular dementia, aortic stenosis.**
4	CIRCUMSTANCES OF THE DEATH Alison Jean Shirley Jeanes was admitted to Wythenshawe Hospital on 17th March at 05:29 following an accidental fall at Sunrise Care Home. She was on anticoagulation and had a head injury. Her INR was 8.3. The aim was to reduce it to below 1 after advice from haematology. Neurosurgical advice was not given until the following day. The CT scan was not reported on until 11:45. It had not been expedited after triage at 05:29. Repeated doses of Vitamin K over the following days did not bring her INR to the target level. Further haematology advice was not sought until 26th March. The reasons why are unclear. A scan on 26th March showed the bleed had progressed. She was subsequently placed on palliative care and died at Wythenshawe Hospital on 4th April 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. – 1. The inquest heard that whilst contact was made with the Neurosurgical team at Salford Royal Hospital on the day of her admission there was

	no conversation with a Doctor from that team until the day after her admission. As a result there was no expert neuro input into her care for 24 hours. There was no evidence that there was any attempt to chase up contact earlier. 2. Mrs Jeanes was brought into hospital by ambulance at the direction of a GP who recognised that she had a suspected head injury and was on warfarin. The GP recognised that the NICE guidance suggests there is an 8 hour window for patients on warfarin with a suspected head injury. Her fall had been at 23.58 on 16th March. The inquest heard that she was triaged but her CT scan was not expedited and was not reported on until 11.45 almost 12 hours after the fall. There was no evidence of a system that would fast track such cases for a CT scan. 3. The inquest heard that haematology advice on the day of admission was to reduce her INR. This advice was reconfirmed by the neuro surgeons the following day. There were differences in the recommendations and it was not entirely clear how that difference was being managed. In any event despite repeated attempts with Vitamin K Mrs Jeanes INR remained above the target. Further advice from the haematologist was not sought until 26th March some 9 days after her admission. It was unclear why that delay had occurred as the notes suggested it had been recognised that advice should have been sought previously but this had not been followed up. There was no evidence before the inquest of what system was in place or who would take responsibility for follow up in such a situation.
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 2nd December 2020. 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 Mr [redacted] son of the deceased, and Sunrise Senior Living, 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** **07.10.2020**