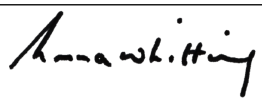
Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: Mr Stephen Conroy, Chief Executive, Bedford Hospital NHS Trust
1	**CORONER** I am Emma WHITTING, Senior Coroner for the area of Bedfordshire and Luton Coroner Service
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 30 April 2019 I commenced an Investigation into the death of Sarah YOUNG aged 34. The investigation concluded at the end of the Inquest on 28 January 2020. The conclusion of the Inquest was a Narrative Conclusion: *The Deceased died from an extensive cerebral sinus thrombosis; the delay in her receiving the appropriate medical treatment may have reduced her chances of survival but could not be said to have contributed to her death.* The medical cause of death was: Ia Bilateral Venous Infarction Ib Cerebral Venous Sinus Thrombosis
4	**CIRCUMSTANCES OF THE DEATH** On 9 April 2019, after suffering with headaches for 2 days, the Deceased was admitted by ambulance to Bedford Hospital with increasing confusion, immobility and fluctuating levels of consciousness. Following her arrival at the Emergency Department at 16.43 hours, she underwent a CT head scan. The Neurosurgical Team were contacted and advised that, as there was a suspicion of a venous sinus thrombosis, she should also have a CT venogram and receive a neurological review. Although she subsequently required care under the Intensive Care Unit and underwent a CT venogram at 21.28 hours, she did not receive a neurological review until 16.15 hours on 10 April 2019; the neurological review resulted in advice to start her on intravenous heparin which was commenced at 17.17 hours that same day. Her condition did not improve and she was declared to have suffered brain-stem death at 12.30 hours on 12 April 2019. Although earlier treatment with intravenous heparin could have increased her chances of

	survival, the medical opinion available at the Inquest was that it would not have prevented her death.
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 : (1) Although Sarah was referred to the Medical Team at 20:00 on 9 April 2019 whilst she still in the Emergency Department awaiting the CT venogram, she was never seen by them. The evidence to the Inquest from the Medical Registrar on call that evening was that *"if a decision to admit to ITU is made, an immediate or urgent medical review is not required, as the patient is under the direct care of the ITU team"* yet the evidence from one of the ITU Consultants in charge of her care was that the ITU Team do rely on the Medical Team to assist in progressing a diagnosis(including involving a Neurologist where required) and that it was a matter of regret for him that there had not been more Medical advice in this case; (2) Although the Neurosurgical Team had advised the Bedford Emergency Department Team at 19.45 hours on 9 April 2019 that a Neurological opinion should be sought alongside the CT venogram, such opinion was *not* sought until 16.15 hours on 10 April 2019 (the following day) and, even then, only after further prompting from the Neurosurgical Team. The Inquest heard that a Neurological opinion was likely to have involved immediate consultation with the on-call Neuroradiologist which would have resulted in a much earlier diagnosis and treatment of the Cerebral Venous Sinus Thrombosis; (3) The Inquest heard that referrals to the Bedford Neurologist (only available during Monday - Friday working hours) are not always picked up through the standard referral system and often require personal 1:1 contact between clinicians.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Stephen Conroy, 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 06 April 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 Roland Sinker, Chief Executive of Cambridge University Hospitals NHS Foundation Trust and [redacted] (Deceased's brother).

	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	 Emma WHITTING Senior Coroner for Bedfordshire and Luton Coroner Service Dated: 10 February 2020