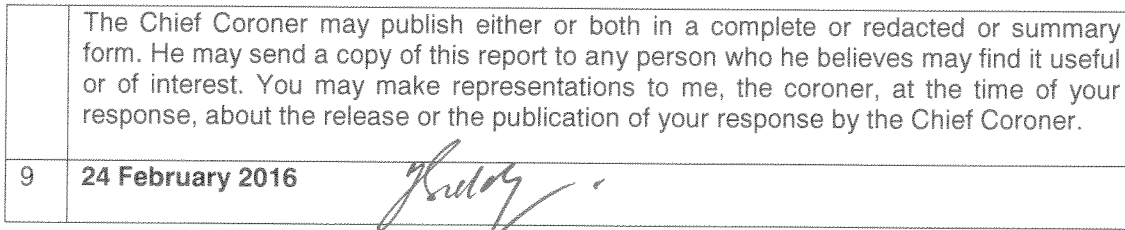
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive, The Royal Wolverhampton Trust, New Cross Hospital, Wolverhampton, WV10 0QP** 2. **Family of the late Mr's Rollason.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 30 December 2015, I commenced an investigation into the death of Mrs Marie Rollason. The investigation concluded at the end of the inquest on 19 February 2016. The conclusion of the inquest was the deceased died by way of natural causes contributed to by neglect. The cause of death was: 1a. Pulmonary Embolism
4	**CIRCUMSTANCES OF THE DEATH** 1. Mrs Rollason was a 43 year old woman who sustained a head injury during a fall in her bathroom at her home on the 19 December 2015. She was admitted to New Cross Hospital Emergency Department in Wolverhampton at around 11:45pm. The laceration was sutured and a computerised topography (CT) scan performed. The CT scan did not show any evidence of fractures or haemorrhages. The injury was recorded as a laceration to the right side of forehead after a fall. 2. She was later discharged home the following morning on the 20 December shortly before 4am. She was provided with a leaflet advising that if she had any further loss of consciousness then she should seek medical attention. 3. Over the course of the next several days she had a number of periods of loss of consciousness and was re-admitted back to the Accident and Emergency Department on the 23 December after she collapsed/fainted at her GP's surgery. 4. She was examined at the same Hospital and her observations recorded. An electrocardiogram (ECG) trace was also recorded. This revealed an abnormality in the trace which can be indicative of changes that occur during a pulmonary embolism. However the Junior Doctor recorded the ECG trace "was okay" and she wasn't kept in for further observation but instead discharged and advised that if the dizziness/fainting spells continue then she should be referred to a cardiologist via her GP. 5. She continued to have fainting spells and loss of consciousness at home and then on the 29 December collapsed again at her GP's surgery and sadly,

	despite resuscitation attempts she died.
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. Evidence emerged during the inquest that Mrs Rollason had at least five periods of loss of consciousness at home by the time she visited her GP's Practice on the 23 December 2015. 2. When she was admitted back to the Hospital on the 23 December 2015, an ECG trace revealed an abnormality in the trace which can be indicative of changes that occur during a pulmonary embolism. However the Junior Doctor recorded the ECG trace "was okay". She wasn't kept in for further observation but instead discharged and advised that if the dizziness/fainting spells continue then she should be referred to a cardiologist via her GP. This was effectively a missed opportunity to render basic medical care. 3. The Consultant who gave evidence suggested that the ECG trace was a potential "Red flag" and he would have admitted her for further observation given that she had no previous cardiac related complaints and to try and understand the basis for her loss of consciousness. He went on to confirm in his opinion that on the balance of probability this was a failure in basic medical care. 4. Moreover, during the inquest the Consultant gave evidence that in his opinion, had she been kept in Hospital and observed, then on the balance of probability it is more likely than not she may have survived. Further tests including the D-Dimer test could have been done to confirm the diagnosis and appropriate treatment commenced.
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. 1. A review should take place in the identification and treatment of Pulmonary Embolism and consideration of further training in the interpretation of ECG results for the staff involved.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 April 2016. 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; family of the late Mr's Rollason. 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	**24 February 2016**

[IL1: PROTECT]