	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mrs A James, Chief Executive, University Hospitals Plymouth NHS Trust**
1	**CORONER** I am Andrew James Cox, Assistant Coroner for Plymouth Torbay and South Devon.
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 22 September 2017, I commenced an investigation into the death of Terence Douglas Thornton, then aged 82. The investigation concluded at the end of the Inquest on 3 April 2019 . The conclusion of the Inquest was that Mr Thornton died as the result of an accident to which a known complication of necessary medical treatment contributed. The medical cause of death was given as:_ 1(a) Acute Subdural Haematoma 1(b) Fall 1(c) Postural Hypotension II Warfarin Therapy for Deep Vein Thrombosis
4	**CIRCUMSTANCES OF THE DEATH** On 16 September 2017, Mr Thornton was admitted into Derriford Hospital following a fall in which he struck his head. He was receiving warfarin for previous DVTs. A CT of his head was reported as being normal. (In fact, a subsequent review identified a subtle, small subdural haemorrhage.) On 17 September 2017, Mr Thornton was discharged to Liskeard Community Hospital arriving at approximately 18:50 hours. At approximately 19:00 hours on 18 September 2017, Mr Thornton was given a dose of enoxaparin. At 07:30 hours on 19 September 2017, he was found comatose in bed. He was taken to Derriford Hospital where a further CT scan revealed a catastrophic expansion of the earlier (missed) subdural haemorrhage. Mr Thornton deteriorated and died in Derriford on 19 September 2017.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) At the Inquest I heard evidence from [redacted] Clinical Director for Radiology at Derriford Hospital. He told me that, currently, there are 44 radiologists working within the Trust. He told me that he believed there was a need for up to a further 16 clinicians across a range of specialities. (2) I also heard evidence from [redacted] who felt that work pressures may have caused or contributed to the error that occurred in this instance. (3) It is not the first time that shortages of radiology clinicians has been brought to my attention at Inquest. I am aware that there are difficulties in this regard nationally but I am concerned that the

	problems in Derriford appear to be worsening with the consequent risk that similar fatalities may occur in the future. In the circumstances, it is my duty to report the situation to you so that you may consider what action needs to be taken to address the 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 1 June 2019. 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 - [redacted] 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	Dated 3 April 2019 Signature_____ **Andrew Cox, Assistant Coroner for Plymouth Torbay and South Devon**

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