REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health 2. NICE 3. Pennine Acute NHS Trust 4. Chief Coroner
1	**CORONER** I am Ms Julie Robertson, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 10 May 2016 I commenced an investigation into the death of **Dildar Shariff.** The inquest into Mr Shariff's death was heard on 7 September 2016.
4	**CIRCUMSTANCES OF DEATH** Mr Shariff died on 10 May 2016 at Fairfield General Hospital having been admitted following a cardiac arrest at his home address that day. He had had an unwitnessed fallen from a chair onto his kitchen floor on 8 May and attended at the Urgent Care Centre promptly following that fall. Neither a CT scan nor additional neurological observations were undertaken during that consultation. Mr Shariff attended the Urgent Care Centre again on 9 May with a history of head pain and recent vomiting. No CT scan was undertaken notwithstanding those symptoms and Mr Shariff was discharged home. On 10 May Mr Shariff was taken to hospital by attending paramedics where the presence of an intracerebral haemorrhage was confirmed. Mr Shariff was undergoing haemodialysis, which placed him at increased risk of haemorrhage. This was not appreciated by attending clinicians due to this not being referred to within the NICE guidelines for head injuries.
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:- Evidence was given that patients who are undergoing haemodialysis or with significant uremia due to renal failure, such as Mr Shariff, are at increased risk of a haemorrhage and that this is not commonly known within the medical profession or referred to in the relevant NICE guidelines. This lack of awareness could create a risk that other deaths will continue to exist or occur in the future and whilst I am satisfied that the Trust have taken this matter very seriously, in that they have implemented appropriate measures to reduce the risk of this occurring in the future, I am concerned with the National picture as I am mindful that it may take some time for the significance of a head injury within patients with undergoing haemodialysis or with significant uremia due to renal failure to be incorporated into the NICE guidelines.

6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 19 October 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 namely:- The family of the deceased. 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 from. 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	Date: 7/Sept/2016 Signed: