REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: SECRETARY OF STATE FOR HEALTH**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 THE 9TH April 2014 I commenced an investigation into the death of **Joyce Nelson born 17th August 1919**. The investigation concluded on the 21st August 2014 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a Bronchopneumonia 1b Traumatic pelvic fractures, congestive cardiac failure due to atrial fibrillation, mitral and tricuspid regurgitation and pulmonary hypertension 11. Chronic kidney disease**
4	**CIRCUMSTANCES OF THE DEATH** **Just before midnight on the 7th March 2014 she fell at her home address and fractured her pelvis in several places.**
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. She was admitted to the Emergency Department at Stepping Hill Hospital shortly after midnight yet was not assessed by a doctor until 04.10 hours. I was told that the Department was fully staffed but there is a national shortage of Doctors specialising in emergency medicine.** **2. Chest and hip X-rays were carried out but the results were not documented by the doctor who was simply too busy to do so.** **3. Patient was to be discharged (even though it was later shown that she had a multi-fractured pelvis).** **4. There were very considerable delays in reporting the imaging results, and I was told that this is due to a national shortage of Radiologists.** **IT SEEMS THEREFORE THAT THERE IS A NATIONAL SHORTAGE OF THE VERY DOCTORS WHO THIS PATIENT NEEDED, AND THIS SHORTAGE LED TO DELAYS IN TREATMENT WHICH WERE UNACCEPTABLE AND DELETERIOUS TO THE PATIENT'S HEALTH.**

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 **4th November 2014**. 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 [redacted] **(SON OF THE DECEASED).** I have also sent it to **The Chief Executive, Stockport NHS Foundation Trust** 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	**9/9/14** **John Pollard, HM Senior Coroner**