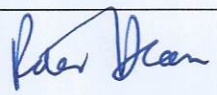
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Medical Director, West Suffolk Hospital**
1	**CORONER** I am Dr Peter Dean, senior coroner for the coroner area of Suffolk
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 25th of February 2013 I commenced an investigation into the death of Else Merete-Harvey Samuel, aged 89. The investigation concluded at the end of the inquest on the 21st of May 2014. The conclusion of the inquest was that Mrs Harvey-Samuels 'Died from complications following a fall and pelvic fracture, contributed to by significant pre-existing natural disease.' The cause of death was found to be 1a Bronchopneumonia, Bone marrow and fat embolism and anaemia due to 1b Fall with pelvic fracture and haematoma, with contributory causes of Recent organising myocardial infarction and Coronary artery atherosclerosis. There were matters that became evident which gave cause for concern.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Harvey-Samuel was admitted to the West Suffolk Hospital on the 15th of February 2013 following a fall at her residential home which resulted in groin pain, and the possibility of a hip or pelvic fracture was considered by the GP who referred her to hospital. Radiographs at that time did not reveal any fractures. Mrs Harvey-Samuel's condition was complicated by other medical issues and pain control remained a problem. Repeat radiographs were requested out of hours because of continuing problems but the radiographer questioned the request and some views were not repeated, including the pelvis. The clinical history accompanying the request had not given the whole picture and the expected communication between senior clinician and radiologist, after the radiologist declined to do some views, did not occur. Following Mrs Harvey-Samuel's subsequent death a pelvic fracture was found at post mortem, along with significant natural disease. A clinical incident was raised and investigated following the x-ray problems but this did not answer all of the issues raised by the incident. While it is accepted that there would have been no active management had the existence of the pelvic fracture been established in life, and the tragic outcome was still likely to have occurred, an accurate diagnosis would have assisted the clinical management greatly and, without attention to the issues raised by this very sad situation, there remains a risk of other fatalities occurring if accompanying clinical histories are not complete and potentially significant radiographs are not taken as a result.
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) Doctors requesting radiographs or other imaging investigations (whether out of hours or not) must include sufficient clinical information to explain why the investigation is

	indicated to avoid the request being rejected, and also to inform the radiologist who reports on the subsequent images what the relevant clinical history was. (2) In the event of further need for justification of an out of hours investigation, discussion between senior clinician and senior radiologist should take place and be documented. (3) In any post untoward incident investigation, the system for determining the correct level of post event analysis, and the investigation itself, must be sufficiently robust to establish fully what occurred and to take any statements required as near to the time of the event as possible so as to identify any lessons that need to be learned.
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 the 15th of August, 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 Mrs Harvey-Samuel's family. 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	**20-6-14**  **Dr Peter Dean**