REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Stockport NHS Foundation Trust:**
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 21st October 2015 I commenced an investigation into the death of Marjorie Booth dob 27th March 1924. The investigation concluded on the 2nd March 2016 and the conclusion was one of **Accidental Death**. The medical cause of death was 1a Respiratory and cardiac Failure 1b Hospital acquired pneumonia 1c Acute stroke 11. Left hip replacement, atrial fibrillation, moderate to severe mitral regurgitation, hypertension.
4	**CIRCUMSTANCES OF THE DEATH** **On the 21st September 2015 she fell at her home address. She tripped over the tail of a coat which she was carrying and fell at the bottom of the stairs. She was taken to hospital where she was examined and had an X-ray taken of her hip but the staff failed to note that she had an impacted fracture of the hip. She returned to the hospital the following day when a CT scan was performed, the fracture was identified and was operated upon. She then sadly declined over the next days and died on the 19th October.**
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. I was told that a CT scan is not routinely asked for in these circumstances, even though it is really the only way to be sure that there is no impacted or un-displaced fracture, because of the risk of exposing the patient to additional levels of radiation. The doctor giving this evidence agreed with me that the minimal risk of the radiation (in a patient over 90 years old) did not compare with the considerable risk of missing such fractures.** **2. Can the Trust explain why there is apparently a policy not to perform scans in such circumstances and whether in fact this policy could be amended.**

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 **29th 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 namely [redacted] (son of the deceased). I have also sent it to the **CQC** 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	**4.3.16** **John Pollard, HM Senior Coroner**