REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mrs Jackie Daniels, Chief Executive, University Hospitals of Morecambe Bay NHS Foundation Trust** **2. The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Department of Health**
1	**CORONER** I am Paul O'Donnell Assistant Coroner, for the coroner area of Cumbria
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 26th May 2015 an investigation was commenced into the death of Mrs Constance Pridmore, aged 82 years old. The investigation concluded at the end of the inquest on 16th March 2016. The conclusion of the inquest was accidental death. The medical cause of death was: 1.(a) Left side haemorthorax (b) Fractured ribs
4	**CIRCUMSTANCES OF THE DEATH** Mrs Pridmore was living independently at home in Barrow-in-Furness at the time she accidentally fell on 3rd May 2015. She was admitted to Furness General Hospital; was the subject of a chest x-ray and head CT scan; diagnosed with pneumonia and admitted to a medical ward for administration of intravenous antibiotics. Mrs Pridmore's condition, whilst initially stable for a couple of days, deteriorated significantly on the evening of 6th May 2015. Her chest x-ray was reviewed by a consultant anaesthetist and several rib fractures were noted; which had not been identified on admission by Accident & Emergency staff. Mrs Pridmore died on 7th May 2015 from a haemothorax associated with the fractured ribs during a procedure to insert a chest drain. Over 2.3 litres of blood was lost from the chest drain from her lung which had accumulated undetected over the previous days following her fall.
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) It was confirmed in evidence by Consultant Radiologist [redacted] that: a) X-rays undertaken on admission to the Accident & Emergency ward at Furness

	General Hospital are not immediately reviewed by a radiologist, but are assessed by the requesting physician. b) The X-rays are eventually reviewed by a radiologist on a non-urgent basis when capacity in the system permits. In the case of Mrs Pridmore, her x-ray was reviewed on 11th May 2015, 8 days after being taken and 4 days after she had died. c) X-rays are not reviewed sooner by a radiologist due to a shortage of available radiologists within the Trust. (2) It was confirmed in evidence by Consultant Physician [redacted] that: a) If Mrs Pridmore's x-ray had been reviewed by a radiologist on 3rd May 2015, it is likely that the rib fractures and associated haemothorax would have been identified and that Mrs Pridmore would have been cared for differently b) on the balance of probabilities, the outcome for Mrs Pridmore would have been the same due to her age and the nature of her injury. However the failure in identifying the fractures denied Mrs Pridmore the opportunity of a more appropriate course of treatment (e.g. pain management and symptom control) and the possibility, all be it remote, of a different outcome (3) It was confirmed in evidence by independent Consultant Radiologist, [redacted] that: a) the rib fractures were only discretely visible on the x-ray and would have required a trained radiologist to identify them b) the shortage of radiologists within the Morecambe Bay trust which prevented Mrs Pridmore's x-ray from being reviewed by a radiologist sooner is reflective of a critical shortage of radiologists in the U.K. c) there are presently approximately **400** vacant consultant radiologist posts unfilled in the U.K. d) the target set in [redacted] 2013 report entitled "NHS Services, Seven days a Week" (Paper NHS121315) for urgent x-rays of impatients to be completed (including the reporting by a radiologist) within 12 hours is far from being achieved both locally by Morecambe Bay Trust, but also nationally by all Health Trusts. This is due in part to a general increase in the use of scans and x-rays as diagnostic aids, but mainly due to the acute shortage of radiologist who are available and trained to interpret the relevant data accurately and in a timely manner. The Keogh targets whilist intended to become reality by the end of 2016/17 are becoming a more distant ideal than a realistically approaching target. It is probable that current delays on both a local and national basis in obtaining in a timely manner, accurate radiologist reports of x-rays and CT scans taken for diagnostic purposes, creates a foreseeable risk that further deaths may well arise as a consequence. Locally, a review of your procedures with regard to the assessment of x-rays is required and nationally, a review into the implementation of the recommendations of the Keogh report is likely to be necessary.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 7th July 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: [redacted] (children of the deceased). I have also sent a copy to the Care Quality Commmission for their information. 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	**Signed:** **Paul O'Donnell** **Dated: 12th May 2016**