Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: -** **Mr Ken Bremner** **Chief Executive** **City Hospitals Sunderland NHS Foundation Trust**
1	**CORONER** I am Derek Winter DL, Senior Coroner for the City of Sunderland
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14th September 2017 Ms Susan Joan Elliott (Sue), aged 70 years, died at Sunderland Royal Hospital. I concluded an Inquest as part of my investigation on 2nd August 2018 recording a conclusion of 'Natural Causes and the consequences of a fall'. The Cause of Death following Post-Mortem Examination was: - Ia Bronchopneumonia Ib Chronic Obstructive Pulmonary Disease and a Fracture of the Neck of the Right Femur (operated)
4	**CIRCUMSTANCES OF THE DEATH** Sue was admitted to Sunderland Royal Hospital on 4th August 2017 after a fall at her home address and had an x-ray of her hip reported on at 12:27 hrs that day. There was an incidence of suspicion that a subcapital fracture was a "possibility", and that a "limited CT would be of use". However Sue was then discharged home on 9th August without CT. Sue was readmitted on 29th August unable to weight bear. X-ray then revealed a subcapital right fracture leading to surgery the following day. Sue was discharged home on 12th September but readmitted on 13th September. Sadly Sue deteriorated and died at 08:18hrs on 14th September 2017.

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5	**CORONER'S CONCERNS** • The orthopaedic surgeon in his evidence confirmed that the x-ray of 4th August 2017 was "reported on and ignored" • No CT scan was undertaken prior to discharge on 9th August 2017, so there was no definitive diagnosis and decisions were based on clinical impression. • Reference was made to new protocols about the treatment of patients presenting with similar conditions such as Sue (particularly for 24/7 CT scanning/reporting), but no documents were produced. • In all likelihood surgery was an earlier possibility for Sue.
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 2nd October 2018. 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: - • Family • City Hospitals Sunderland NHS Foundation Trust and Trust's Solicitors • Secretary of State for Health • CQC 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	Dated this 6th day of August 2018 Signature D Winter Senior Coroner for the City of Sunderland