REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **This report is being sent to:** **The Chief Executive, NHS England**
1	**CORONER** Christopher P Dorries OBE, HM Senior Coroner for South Yorkshire (West)
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** In November 2017 I commenced an investigation into the death of Mrs Elizabeth Glen Self. The investigation concluded following an inquest in June 2018 where the narrative conclusion set out that: *Mrs Self was admitted to hospital on 11th April 2017 following a heart attack. The court finds it more likely than not the she would have survived this episode. Unfortunately Mrs Self suffered a serious fall in hospital when she became entangled in a line attached to her left leg, this left her with serious injuries which were not immediately recognised. Necessary scans and x-ray examinations were ordered some hours later but did not take place for another nine hours or so.* *The court has closely considered these most regrettable delays but the expert advice is that a faster response either in investigation or transfer to Sheffield would probably not have saved Mrs Self's life.*
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are set out in the narrative conclusion shown above. In addition I attach a copy of my closing remarks which is just a single sheet. In summary, this lady with severe heart disease suffered a fall in hospital. She was unlikely to survive from that point onwards but there was a delay in dealing with two x-ray requests and one CT request of more than thirteen hours.

5	**CORONER'S CONCERN** During the course of the investigation my inquiries revealed matters giving rise to a concern. In my opinion there is a risk that future deaths will occur unless action is taken. I am satisfied that the hospital in question has taken appropriate and significant remedial action and I do not therefore find it necessary to address this report to the hospital itself. However, my concern is that this situation can arise elsewhere which is why I address this report to NHS England. The **MATTERS OF CONCERN** are as set out in my closing remarks (attached), that is to say -- a) A moderately senior doctor had put in not one but two x-ray requests that had to be rejected which is suggestive of a lack of necessary training b) A valid CT request had laid unattended for a full morning, the reasons for which were never established but the hospitals own investigation report team formed an impression of a breakdown in communications. c) The overall circumstances were such that neither requests was actually completed until more than thirteen hours after what was a significant fall. The inquest found this to be a criticism of the system then in place rather than of particular individuals. In essence my concern is that those inspecting hospitals in other places should include in their programme establishing that senior staff do actually know how to make a proper x-ray request which will not therefore be rejected and checking systems to ensure that x-ray and CT requests cannot go for a period of hours without resolution.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the named authorities, 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 15th January 2019. I may extend this period upon request. 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, the CQC, Barnsley District General Hospital and to the family of Mrs Self. 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.

Christopher P Dorries OBE

29th October 2019