Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

This report is being sent to:

The Chief Executive, Western Sussex Hospitals NHS Trust

1 CORONER

I am **Robert Simpson**, an Assistant Coroner, for the coroner area of **West Sussex**

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 22nd February 2019 an investigation was opened into the death of Richard Lester Ridout, aged 43. The investigation concluded at the end of the inquest on 26th September 2019. The conclusion of the inquest was that 'Richard Lester Ridout died as a result of Influenza A and streptococcal pneumonia causing sepsis which lead to multiple organ failure.'

4 CIRCUMSTANCES OF THE DEATH

On the 20th January 2019 Richard Ridout was involved in a single vehicle road traffic collision. His vehicle left the road and rolled over. Richard Ridout extricated himself from the vehicle after paramedics arrived. He was complaining of a pain in his shoulder and did not report any additional pain upon c-spine palpation. He reported that he had consumed 40mg diazepam and 8mg Buprenorphine. He stated to the ambulance staff that he had been travelling at 30 mph.
On arrival at St Richard's Hospital he was diagnosed with a fractured scapula. He complained of both neck and shoulder pain. A chest and pelvic x-ray were ordered but Richard declined the latter. He declined a full trauma examination. No additional pain was reported on c-spine palpation. He informed the junior doctor that he had been travelling at 50-60mph.
His c-spine was not imaged, a trauma series CT was not requested and a trauma call was not put out.
On the 29th January 2019 Richard was readmitted to hospital and transferred to St Guy's & Thomas' due to respiratory failure. Fractures of his C7 and C5 vertebrae were discovered along with pulmonary contusions. He was in septic shock and contracted the infections noted above.
I found that the fractures had been caused by the road traffic collision on the 20th January 2019.

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 heard evidence that a trauma call would be put out if certain circumstances arose. These included where a high speed was involved in an RTC. In this inquest it was clear that inconsistent information was given about the speed and the junior doctor was informed that the speed was 50-60mph. Despite this inconsistency and evidence of a high speed collision no trauma call was put out.
(2) I heard evidence that no trauma series CT scan was carried out or trauma call put out despite Richard

suffering an injury requiring a high degree of force (fractured scapula) and having been involved in a roll-over RTC.

(3) There was evidence available to the medical staff involved in his treatment that Richard had consumed diazepam and buprenorphine prior to his arrival at hospital. Despite this information being available, the distracting injury to his shoulder and a complaint of neck pain no imaging of his c-spine was carried out.

(4) Whilst the undiagnosed conditions did not contribute to Richard Ridouts death I am concerned that the failure to escalate the assessment and treatment of a person involved in such a road traffic collision could lead to deaths in the future.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe 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 29th November 2019. 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 Person namely [redacted]

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.

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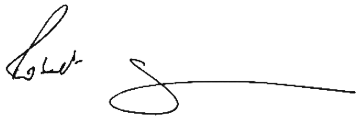

Robert SIMPSON
Assistant Coroner for
West Sussex Coroner's Service
Dated: 02/10/2019