**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

THIS REPORT IS BEING SENT TO: 1) [redacted], Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust.

**CORONER**

I am Chris Morris, Area Coroner for Greater Manchester (South).

**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

**INVESTIGATION and INQUEST**

On 1st December 2021, Alison Mutch OBE, Senior Coroner, opened an Inquest into the death of Kathleen Stewart who died on 4th November 2021 at Tameside General Hospital, Ashton-under-Lyne, at the age of 92 years. The investigation concluded with an Inquest which I heard on 28th June 2022, and which concluded that Mrs Stewart had died as the consequence of an accident.

**CIRCUMSTANCES OF THE DEATH**

On 27th September 2021, Mrs Stewart fell at her care home, and reported pain in her groin. An ambulance was called which arrived on 28th September 2021 and conveyed her to Tameside General Hospital.

There, Mrs Stewart was seen in the Emergency Department by a Middle Grade doctor who arranged a series of tests including x-rays of her pelvis and hip. The Middle Grade doctor's opinion was that these x-rays did not show any evidence of a fracture.

As such, Mrs Stewart was discharged back to her care home. There, she was noted to be significantly less mobile and often in pain.

Mrs Stewart was readmitted to hospital on 15th October 2021, following which she progressively deteriorated until her death on 4th November 2021.

A Post Mortem Examination concluded that the medical cause of Mrs Stewart's death was:

1a) Bronchopneumonia;
II) Dementia, Right superior pubic ramus fracture.

**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. The court heard evidence that, whilst the Middle Grade doctor who treated Mrs Stewart in the Emergency Department did not identify any bony injury, a Radiographer who formally reported on the pelvic X-Ray the following day identified a minimally displaced fracture of the right superior pubic ramus;

   It is a matter of concern that this X-Ray report was not acted upon, and as such Mrs Stewart did not receive the indicated follow up of analgesia and referral for physiotherapy;

2. It is a further matter of concern that the Trust does not appear to have undertaken any specific investigation as to why this was the case. As such, the Trust has not taken the opportunity to:-
   a) Identify what went wrong in Mrs Stewart's case and ascertain what learning can be derived from the incident;
   b) Ascertain whether this was an isolated incident or whether there was (or is) a broader problem in relation to acting on abnormal reports of clinical imaging (and if so, the nature and extent of any such problem); or
   c) Consider the fitness for purpose of the system in place within the Emergency Department for acting on abnormal reports of clinical imaging.

**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.

**YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by **11th September 2022.** 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

**COPIES and PUBLICATION**

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of the family.

I have sent a copy of my report to the Care Quality Commission, Tameside Metropolitan Borough Council and NHS Tameside and Glossop CCG 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.

Dated: 17th July 2022

Signature: Chris Morris, HM Area Coroner, Manchester South.