MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroners, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 16652044

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **CEO, Barking, Havering & Redbridge NHS Trust** [redacted] 2. **RT Honorable Therese Coffey, Secretary of State for Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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 7th January 2022 this Court commenced an investigation into the death of Peter Mantador Ross, age 70 years. The investigation concluded at the end of the inquest on 11th October 2022. The conclusion of the inquest a narrative conclusion incorporating a finding of neglect; *Narrative Conclusion* *On 8th July 2020 Mr Peter Mantador Ross sustained a fall down stairs at home. In the course of that fall he sustained a subdural haemorrhage and a cervical*

	spine fracture. *Mr Ross's neck was immobilised by paramedics and he was taken to hospital by ambulance where he underwent diagnostic tests.* *CT images were misinterpreted which resulted in the spinal fracture remaining undiagnosed.* *An undocumented decision was made to cessate immobilisation of Mr Ross's spine.* *A concern was later raised that Mr Ross had in fact sustained a spinal injury, an urgent MRI scan was requested. No order was given to recommence immobilisation of the spine pending an MRI.* *The urgent MRI was delayed for two days. The lack of spinal immobilisation after renewed suspicion of spinal injury contributed to a subsequent cardiac arrest, tetraplegia and tetraparesis.* *On 19th October 2021 Mr Ross suffered an episode of aspiration made more likely by his injuries. As a result of that aspiration he developed pneumonia which caused his death.* *Neglect contributed to Mr Ross's death "* Mr Ross's medical cause of death was determined as; *1a Broncho-pneumonia* *b Cervical spine fracture and injury (2020)* *c* *II Cardiac failure*
4	**CIRCUMSTANCES OF THE DEATH** **See narrative above**
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 could 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.A CT C-spine requested on the admission on 8 July 2020 was misreported as normal. 2. Following that report, during the initial referral of Mr Ross to neurosurgery, the reviewing surgeon noticed an abnormality in Mr Ross's CT Spine, made no note of his finding and did not escalate his finding to any other clinician. 3. Prior to burr-hole surgery, the neurosurgical team did not review the CT C spine images. 1. A CT C-spine requested on the admission on 8 July 2020 was misreported as

	normal. 2. Following that report, during the initial referral of Mr Ross to neurosurgery, the reviewing surgeon noticed an abnormality in Mr Ross's CT Spine, made no note of his finding and did not escalate his finding to any other clinician. 3. Prior to burr-hole surgery, the neurosurgical team did not review the CT C spine images. 4. Repeated failures in communication between; neurosurgical, emergency medicine, nursing staff, and physiotherapists led to serious harm to Mr Ross. 5. Clinical records were poorly maintained, exacerbating the lapses in communication between those treating Mr Ross.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 **3rd January 2023**. 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 the family of Mr Ross, the Care Quality Commission and the General Medical Council. I have also sent it to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 4 November 2022 [SIGNED BY CORONER]**