REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care and NHS England
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 12th July 2022 I commenced an investigation into the death of Celia Sanderson. The investigation concluded on the 12th January 2023 and the conclusion was one of **Narrative: Died from injuries sustained in a road traffic collision where there was a delay in identifying the severity of the injuries sustained.** The medical cause of death was **1a) Acute Myocardial Infarction; 1b) Multiple Injury, Acute Bilateral Subdural Haematomas; 1c) Road Traffic Collision**
4	CIRCUMSTANCES OF THE DEATH Celia Sanderson was involved in a Road Traffic Collision. She was then taken to Wythenshawe Hospital. There was a delay in triage due to demands on the Emergency Department. Triage did not pick up on her being a potential silver trauma case. A CT scan was not ordered at that time. She was triaged to be seen within 1 hour. Due to demands on the Emergency Department she was not seen by a clinician until approximately 6 hours after triage. This was not a senior clinician assessment due to staffing levels and demands on the department. The junior doctor found no significant injuries but asked for a more senior review. This was delayed due to the workload demands on the middle grade doctor. On assessment the middle grade doctor identified a CT scan was required. The CT scan was requested at 04.21. The scan was reviewed by a clinician at 7am before the radiology report itself was available. The actual report was delayed due to workload demands on the radiology registrar. It was identified that she had severe injuries from the road traffic collision and a transfer to a major

	trauma centre was required. Celia Sanderson began to deteriorate whilst further tests were undertaken and awaiting transfer. The further tests identified she had also sustained significant neurological damage from the road traffic collision. She continued to deteriorate and had an acute myocardial infarction. She died at Wythenshawe Hospital before she could be transferred.
5	<u>CORONER'S CONCERNS</u> 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. Demands on the Emergency Department due to the volume of people waiting to be seen meant that Mrs Sanderson had a long wait for a clinician review far outside the expected target time. The inquest heard evidence that delays such as hers were common throughout that period and were due to the volume of people attending and staff available to deal with them; 2. The inquest heard that amongst the challenges faced was a shortage of ED consultants and ED middle grade doctors. Mrs Sanderson's time at the hospital included late evening and the early hours of the morning. The inquest heard that across the NHS during these hours the number of staff at these grades in an ED is significantly reduced. Historically that had been a quieter period however demands on ED meant that was no longer the case. As a consequence senior reviews of patients were further delayed. An earlier review by a senior clinician was the inquest heard likely to have identified her as a potential silver trauma case and ensured she was moved to a trauma centre for appropriate treatment before she began to deteriorate; 3. Evidence given to the inquest indicated that the ability to carry out and report promptly on CT scans was essential if trauma cases were to be identified with sufficient speed to ensure a timely transfer to a trauma unit. The inquest heard that timely transfer to a trauma unit was likely to significantly improve the outcome for a trauma patient. The inquest was told that once CT scans were requested there were often delays due to a shortage of suitably qualified staff to carry them out and then to report on them. As an example of this the inquest was told that overnight 1 radiology registrar was responsible for reporting on CT scans for 3 hospitals (Wythenshawe, the MRI and RMCH) In Mrs Sanderson's case this meant that the ED clinician had to wait for it to be carried out and then assess the CT scan without the report; 4. The inquest heard evidence from a trauma specialist about the

	importance of recognising “silver trauma”. There was recognition amongst trauma specialists of the high risk of significant trauma amongst elderly patients such as Mrs Sanderson even from what could appear to be relatively minor incidents. As a consequence major trauma centres generally had developed protocols that assisted staff at triage to pick up such cases and prioritise them and set a low threshold for an early CT scan. Such protocols were not generally in force in DGH settings. The evidence was that there needed to be steps taken to increase awareness amongst DGH ED staff to pick up these potential silver trauma cases on arrival in order to expedite discussion with and transfer to a trauma centre and increase the chances of survival.
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 7th April 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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted] on behalf of the Family and [redacted] on behalf of Manchester University NHS Foundation Trust, 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.
9	**Alison Mutch OBE** **HM Senior Coroner**  **10.02.23**