H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive, Gloucestershire Hospitals NHS Foundation Trust, Gloucester Royal Hospital, Great Western Road, Gloucester GL1 3NN**
1	**CORONER** I am Katy Skerrett, His Majesty's Senior Coroner for Gloucestershire.
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 8th March 2021 I commenced an investigation into the death of Donald Charles Brown. The investigation concluded at the end of the inquest on the 13th December 2022. The conclusion of the inquest was a narrative conclusion. The medical cause of death was 1A Aspiration pneumonia, 1B C1/C2 fracture dislocation.
4	**CIRCUMSTANCES OF THE DEATH** Donald Charles Brown "Donald" was an 87 year old man who suffered a fall at home on the 31st January 2021. He was taken to hospital and underwent CT examination. No fractures were reported. Following further investigations he was discharged home. Following discharge Donald continued to experience neck pain and difficulty swallowing. He was readmitted to hospital on the 26th February 2021 and was treated for aspiration pneumonia. Further CT imaging demonstrated that he had suffered a displaced fracture of the C2 vertebra with spinal cord compression. This injury had been sustained in his fall on the 31st January. It was visible on the CT imaging taken on that day. However it was not reported. It is likely that the severity of this injury led to his swallowing difficulties and caused aspiration pneumonia. Neurosurgical opinion was sought and advised against operative intervention. Donald's condition thereafter steadily deteriorated and he passed away at 08.15 hours on the 4th March 2021.
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. The significant understaffing of the Radiology department at the hospital. 2. The national shortage of radiology trainee posts. 3. The expectation that the reporting of all scans including non urgent, will be done within an hour. 4. The appointment of call handlers to triage calls to reduce the demands on the radiologists' time has been delayed due to cost.

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 4pm 28th March 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 (1) Taynton's Solicitors representing the family of Donald Brown, [redacted] (2) National Medical Director, [redacted] (3) Royal College of Radiologists, 63 Lincoln's Inn Fields, London WC2 3JW. 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	Dated 31st January 2023 Signature_____ _____ Ms K Skerrett His Majesty's Senior Coroner for Gloucestershire