REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: 1) NHS England**
1	**CORONER** I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 October 2023 I commenced an investigation into the death of George Barry Broadhurst. The investigation concluded on the 30th April 2024 and the conclusion was one of Narrative: Died from the complications of a fracture sustained in an accidental fall where the fracture was not recognised immediately. The medical cause of death was **1a) Pulmonary Embolism and Community Associated Pneumonia 1b) Infected traumatic thoracic vertebral fracture 1c) Fall.**
4	**CIRCUMSTANCES OF THE DEATH** George Barry Broadhurst lived independently and was mobile. Around the 4th September 2023 he had an accidental fall at his home address. He reported to his GP that he had injured his lower back and was in pain. He was advised to attend A&E but declined. He managed with pain relief at home. He continued to manage at home until 25th September 2023 when he went to Tameside General Hospital. An x-ray was taken. He was discharged. The x-ray showed a fracture of the vertebrae but this was not identified at that time. A radiologist reported on the x-ray 2 days later and it was to be reviewed by a Consultant but was not done due to backlogs. On 1st October 2023 he went to Stepping Hill Hospital with worsening back pain. The fracture was identified and he was discharged home with pain relief and treatment for a lower respiratory tract infection and with support in the community. At home he deteriorated rapidly. He was readmitted on 7th October to Stepping Hill Hospital. He had a collapsed

	lung, pulmonary embolism and an infected fractured vertebra. The collapsed lung and pulmonary embolism were as a consequence of lack of mobility due to the fracture. He deteriorated and died at Stepping Hill Hospital on 10th October 2023.
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. The inquest heard evidence that the delay in reporting of X rays by radiologists is not unique to Tameside but is a national picture caused by a shortage of radiologists and trained reporting radiographers. The impact of the shortage is that ED doctors are interpreting x rays in highly pressured situations without specialist input and with a consequential risk of missing more subtle fractures. This means that patients are discharged with fractures rather than appropriate treatment or conversely are given unnecessary treatment that then has to be reversed once a specialist review takes place. 2. The knock-on impact of the delay in reporting is that once the radiology reports are available they then have to be reviewed in conjunction with the notes by a consultant days after the attendance to ensure the treatment given fits with the reported findings. This is a significantly more time-consuming process than them being looked at in real time and results in ED consultant resource being diverted away from the day to day demands of ED. Thus, placing a greater strain on clinicians in ED and stretching resources more thinly. 3. The evidence given was that the level of pain that Mr Broadhurst still had in the community after 1st October was not in keeping with a healing fracture. The inquest was told that it was important that community/primary care teams were trained to understand how "normal" pain, in the context of a fracture being managed in the community, would present and what was a red flag/ deteriorating situation. Training on expectations around healing fractures would ensure what was a life-threatening deterioration was picked up and escalated at the earliest possible point.

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 24th July 2024. 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 1) [redacted] on behalf of the family; 2) Weightmans LLP on behalf of Tameside General Hospital and; 3) Browne Jacobson LLP on behalf of Stepping Hill Hospital, 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** **HM Senior Coroner**  **29.05.2024**