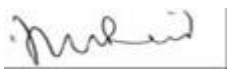
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Acting Chief Executive, Worcestershire Acute Hospital NHS Trust ("the Trust"), Charles Hastings Way, Worcester WR5 1DD.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S 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 3 September 2024 I commenced an investigation and opened an inquest into the death of Jordanne Rose ROBERTS. The investigation concluded at the end of the inquest on 25 June 2025. The conclusion of the inquest was that Jordanne *"died from an undiagnosed pulmonary embolism. Her death was contributed to by neglect"*.
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Jordanne come by her death?", I recorded as follows: *"On 10.8.24 Jordanne Roberts was assessed in the Emergency Department of the Alexandra Hospital, Redditch after falling down stairs at her home in Kidderminster. The locum doctor who assessed her discharged her home without waiting to read a full CT scan report, which identified that she had a pulmonary embolism. On the morning of 12.8.24 Jordanne collapsed suddenly at home, and died a short time later. A post mortem examination confirmed the cause of death to be a pulmonary embolism. Her death would probably have been prevented if the pulmonary embolism had been identified and treated in hospital."*
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) Jordanne's death arose because a locum doctor, said to be the most senior doctor on duty in the Emergency Department on 10.8.24, did not know that her CT scan taken that day would be reported in two parts. The initial report did not mention the presence of a pulmonary embolism, but did make clear that a second and final report was to follow. The doctor proceeded to make the decision to discharge Jordanne without reading the second and final report, which highlighted the pulmonary embolism;

	2) In her evidence at inquest, [redacted] (Head of Patient Safety at the Trust) confirmed: (a) that all of the Trust's own employed doctors receive training so that they ensure that both parts of any CT scan report are read; (b) that all new locum doctors working for the Trust are provided with an induction pack, which highlights the requirement to read both parts of any CT scan report. However, [redacted] was unable to confirm that steps have been taken to ensure that all locum doctors already working at the Trust have received the equivalent training. She indicated that they have been invited to attend education sessions in which this topic has been covered, but that no record is kept of whether those doctors did in fact attend. I am therefore concerned that unless and until the Trust is able to ensure that all locum doctors working at its hospitals have received training about the need to read both parts of a CT scan report, there remains a risk that (as in this case) life-threatening conditions may go undiagnosed, and consequently that patients' lives may be put at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Acting Chief Executive of the Trust, 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 **21 August 2025.** 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: (a) [redacted] (Jordanne's mother). 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. She may send a copy of this report to any person who she 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	**26 June 2025**  **David REID** **HM Senior Coroner for Worcestershire**