	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Nuffield Road Medical Centre**
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 14th March 2013 I commenced an investigation into the death of James Edward Mansfield whose date of birth was 15 February 1943. The investigation concluded at the end of the inquest on 10 October 2013. The medical cause of death was: 1a) Right haemothorax 1b) Multiple rib fractures 1c) Fall 2) Atrial fibrillation with anticoagulation Hypertensive heart disease Hepatic cirrhosis The conclusion of the inquest was that Mr Mansfield died as a result of bleeding into his chest due to rib fractures sustained in a fall, coupled with treatment with warfarin.
4	**CIRCUMSTANCES OF THE DEATH** Mr Mansfield had a long history of lung related complications and had multiple occurrences of pneumonia. He was on warfarin. On 25 February2013 he fell at this home. He saw the GP who referred him to the x-ray department at Addenbrookes. An x-ray showed four displaced rib fractures. He was reviewed in the A+E where he said he was comfortable and he was discharged to the care of his GP, with a leaflet. On 27 February [redacted] called the GP advising of Mr Mansfield's pain and she requested stronger painkillers. These were prescribed but he was not seen. The discharge summary was received by the GP Surgery on 28th February and was reviewed on 6 March. On 8 March Mr Mansfield called for the GP. He was admitted to Addenbrookes and a chest x-ray revealed a large right haemothorax. Mr Mansfield passed away at 18.55 on 9 March 2013.
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 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) Mr Mansfield had an xray and was discharged from Addenbrookes Hospital on 25 February. You have arranged that that the hospital post discharge letters to your surgery. This was not received received until 28th February 2013 by which time Mrs Mansfield had called requesting stronger pain killers. The discharge summary was only reviewed by a doctor on 6 March. You stated that only if a patient was admitted to hospital would their discharge letter get prompt attention. There was no apparent method for differentiating between discharge summaries which involved serious injuries and those which did not. (2) When [redacted] telephoned the surgery, complaining of Mr Mansfield's pain, strong pain killers were prescribed but he was not seen despite a long history of lung and chest complaints, multiple rib fractures and treatment with warfarin.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that 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 3rd January 2014. 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, Addenbrookes Hospital and [redacted] Similarly, you are 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.
9	**[DATE]** **[SIGNED BY CORONER]**