Coroners
Manchester South

17 September 2013

Chief Executive
Stockport NHS Foundation Trust
Poplar Grove
Stockport
SK2 7JE

Our ref: JSP/KA/00777-2013
Your ref:

Dear Chief Executive

RE: Margaret Theresa CORRIGAN (Deceased)

I write this letter to you pursuant to Regulation 28 of the Coroners (Investigation) Regulations 2013 and pursuant to paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.

On 26 March 2013 I commenced an investigation into the death of Margaret Theresa Corrigan who was born on 31 August 1924. The investigation concluded at the end of the Inquest on 6 September 2013 and the conclusion of the Inquest was that she died as a result of an Accidental Death. The medical cause of death given was 1a) Cerebellar and inferior parieto-occipital infarct due to 1b) Vertebral artery dissection due to 1c) Peg fracture and under Part 2: Clostridium Difficile infection.

The circumstances of the death were that on 18 January 2013 the deceased fell on the stairs at her home address and fractured her odontoid peg.

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 as follows

1. Communication between and among medical and nursing staff at your hospital was ineffective and lacked clarity.
2. The patient was seen in the Emergency Department and it was agreed in evidence that the fracture ought to have been diagnosed at that time but it was not, thus meaning the patient was left for a further two days in additional pain and at risk of further spinal damage.
3. The patient remained on the orthopaedic ward when she was suffering at that stage from medical problems and ought properly to have been transferred to a medical team.
4. Whilst she was an in-patient in the hospital, she was issued with an out-patient appointment to attend an orthopaedic clinic.

John S Pollard LI.B. Hons, Senior Coroner

Joanne Kearsley LI.B. Hons Grad.Dip Psych, Area Coroner

[redacted]

Coroner's Court
Mount Tabor, Mottram Street
Stockport SK1 3PA
Telephone: 0161 474 3993
Facsimile: 0161 474 3994

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

You are under a duty to respond to this report within 56 days of the date of this report namely by the 12 November 2013 and I, the Coroner, may extend that period. Your response must contain details of action taken or proposed to be taken setting out the timetable for such action otherwise you must explain why no action is proposed.

I have sent a copy of my report to the Chief Coroner and to [redacted] daughter of the deceased. I am also under a duty to send to 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 publication of your response by the Chief Coroner.

I therefore look forward to hearing from you within the time stipulated.

Yours faithfully

John S. Pollard
Senior Coroner

Cc to:

1. Mrs Langshaw
2. Chief Coroner
3. Derek Winter, Senior Coroner