REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Royal Berkshire Hospital Trust** **2. Medicines & Healthcare Products Regulatory Agency** **3. Anetic Aid Limited**
1	**CORONER** I am Peter J. Bedford, senior coroner, for the coroner area of Berkshire
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 20th June 2011 I commenced an investigation into the death of James Wilson Fyfe aged ninety years. The investigation concluded at the end of the inquest on 12th December 2014. The conclusion of the inquest, before a Jury, was in the terms of the Narrative Conclusion attached to this Report.
4	**CIRCUMSTANCES OF THE DEATH** Mr Fyfe died on 21st April 2011 at The Royal Berkshire Hospital, Reading from pneumonia that was significantly contributed to by a fracture of the cervical spine that he suffered when he fell from a QA3 patients trolley manufactured by Anetic Aid Limited. The fall came about whilst Mr Fyfe was in the X-Ray Department at the Hospital awaiting a hip x-ray. The fall was unwitnessed but two Radiologists were in the adjacent room. The Jury concluded that Mr Fyfe fell as a result of the cot side on the trolley giving way when he applied pressure to it as the result of the Radiologist not locking the cot side in to place but the cot side nevertheless remaining in the raised position, a phenomenon that was apparently known to Staff within the Hospital Trust.
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) It was the Jury's determination on the evidence that the cot side was able to remain in a raised but unlocked position due in part to both the design and maintenance of the trolley. While evidence was given that the Trust had subsequently introduced improved service sheets and had involved the assistance of Anetic Aid Limited in maintenance, repair and training of use of the trolley, it was unclear as to whether this specific problem had been highlighted as needing careful attention in all maintenance schedules for the trolley. (2) The Jury were informed that MHRA were aware of the investigations of the incident trolley but that it did not appear that the issue had been escalated and notified to all Hospital Trusts and agencies that used this type of trolley. The MHRA's actions in being informed of this potential hazard remain unclear, with particular reference to passing on the known risk to such trolley users.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 2nd March 2015. 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 Mr Fyfe's family. 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	**5th January 2015** **Peter J. Bedford** **Senior Coroner for Berkshire**