NHS
Manchester University
NHS Foundation Trust

Trafford Hospitals Division
Moorside Road
Davyhulme
M41 5SL
Tel No: 0161 746 2947

Our Ref: MB/PD/18-010

Date: 28th February 2018

Mr Murray
Coroners Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Murray

Following the inquest into the death of Mr Edwin Hooper that concluded on the 27th September 2017, a regulation 28 report to prevent future deaths has been received.

I enclose the action plan that has been finalised and completed by the divisional management team working with the multi disciplinary teams at Trafford Hospital Division. Evidence of all completed actions are embedded within the plan to give assurance.

In summary the measures put in place are a robust escalation and dissemination plan for any occurrences of CT scanner downtime. This is backed up with senior managers on call and the out of hours team being sent and reminded on the CT scanner downtime protocol (embedded in the action plan). A poster has also been designed and displayed in all relevant clinical areas, which describes the process clearly.

Training on NICE guidelines for the management of hospital acquired head injuries has been undertaken, and is sustained with all new starters having to complete this on induction to the Trust.

I hope this response gives you the assurance that addresses the concerns raised at the inquest.

Yours sincerely

Mary Burney

Mary Burney
Director, Trafford Hospitals Division

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