	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Right Honourable Secretary of State for Health;** Ministerial Correspondence and Public Enquiries Unit Department of Health 39 Victoria Street London SW1H 0EU
1	**CORONER** I am James Newman, Area Coroner for **Lancashire & Blackburn with Darwen**
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 23rd November 2016 an investigation was opened into the death of Kristina CROSS aged 72. The investigation concluded at the conclusion of the inquest on 12th December 2017. The conclusion of the inquest was: Mrs Cross died due to a sudden and catastrophic cardiac event, on a background of pre-existing cardiac changes and other medical conditions and the trauma of a traumatically fractured right femur, delayed surgical fixation and post-operative complications.
4	**CIRCUMSTANCES OF THE DEATH** In brief summary the background is as follows. On 28th August 2016 Kristina Cross was a 72 year old lady, admitted to the emergency department of the Royal Lancaster Infirmary by ambulance following a reported unwitnessed fall to her right side. On admission she underwent examination and assessment, presenting with recorded pain on her right shoulder, tenderness over the right pelvic area, and obviously deformed right wrist. She underwent a trauma CT scan which was reported as showing an old fracture of the right neck of femur, and a colles fracture of the distal ulna with dorsal angulation. Attempts were subsequently made to manipulate the right wrist, unsuccessfully and she was admitted for care. On 3rd September 2016 Kristina Cross was referred for a further plain x-ray of her right hip, given reported ongoing pain. This was initially reviewed by a junior orthopaedic clinician, who re-iterated the opinion of an old fracture, and was further reported by radiology on 28th September 2016 as the same. In the interim period, on 23rd September 2016 Kristina Cross underwent a further x-ray of the right hip which was reviewed and reported as showing a displaced fracture of the neck of femur. Kristina Cross underwent surgical fixation on 27th September 2016, delayed by the initial and subsequent misdiagnoses of the right hip fracture. Post-operatively Kristina Cross suffered wound complications, including wound infections and dislocations of the joint, identified on further CT scanning. Kristina Cross underwent further surgical fixation on 19th November 2016. During the procedure it was reported that she suffered a sudden drop in blood pressure, that initially responded to therapy, however following transfer to the High Dependency Unit, she suffered a further sudden deterioration at 05:30 on 20th November 2016 from which she never fully recovered, and passed away at 08:30 on 20th

	November 2016 at the Royal Lancaster Infirmary. Ultimately the delay in diagnosing the fracture and progressing to surgical fixation significantly contributed to the death of Kristina Cross
5	**CORONER'S CONCERNS** 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. – Evidence from the Lead Consultant Radiologist of the University Hospitals of Morecambe Bay NHS Foundation Trust was that whilst there was an initial misdiagnosis of the hip fracture there was a subsequent significant delay in reporting on plain radiology, due to a shortage of Consultant Radiologists. Furthermore evidence was heard that non-urgent plain radiology is not being reported at all unless specifically requested by clinicians. Evidence was heard that a quarter of positions within the Trust are currently unfilled. The Dalton Review of July 2014 identified that such is a national position, with comparatively low levels of radiologist training and retention with 41% of unfilled consultant radiological posts remaining unfilled for more than 12 months. In brief the concerns arising from the evidence are that a substantial number of consultant posts are unfilled, and that due to shortages of qualified radiologists, radiological investigations, crucial for diagnostic and clinical decision making purposes, are not reported on within the timescales set out within Professor Sir Bruce Keogh's report of 2013, or at all.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **28th February 2018**. 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, namely the family of Kristina Cross and University Hospitals of Morecambe Bay NHS Foundation Trust I have also sent it to the Royal College of Radiologists who may find it useful or of interest. 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	Dated 02/01/2018 Signature for **Lancashire & Blackburn with Darwen**

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