IAN S SMITH
LL.B, Hon DUniv
HER MAJESTY'S CORONER

for the
Stoke-on-Trent and North Staffordshire
Coroner's Area

CORONER'S CHAMBERS,
547 HARTSHILL ROAD,
STOKE-ON-TRENT ST4 6HF
Tel: (01782) 234777
Fax: (01782) 232074
Email: coroners@stoke.gov.uk

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Audlem Medical Practice** [redacted] **Healthcare Governance Manager Patient Safety, Royal Stoke University Hospital**
1	**CORONER** I am Margaret J Jones HM Assistant Coroner for Stoke-on-Trent & North Staffordshire
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 18th July /2017 I commenced an investigation into the death of John Robert Maltby Worthington. The investigation concluded at the end of the inquest on 28th June 2018. The conclusion of the inquest was:- The deceased was a 67 year old male. During the late evening of 3rd April 2017 he was carrying a suitcase up the stairs at his home address when he lost his balance, falling backwards. He was able to call for an ambulance. Paramedics arrived at 8.36pm. The deceased was taken to the Royal Stoke University Hospital, Stoke-on-Trent where he was treated for a head injury. He said he had fallen from 4 steps in height. Pain in his back and neck were noted but other observations were within normal parameters. An x-ray and scan were not considered to be necessary. He declined to stay in hospital overnight and was discharged home the same evening. On 5th April 2017 the deceased complained to his daughter of a sore chest saying he had fallen from the top of the stairs. He was relatively immobile and experienced worsening chest and back pains over the following 2 weeks. On the 12th April 2018 he called an ambulance again complaining of chest pains but declined to go to hospital. He contacted his GP to review the paramedics ECG. The doctor asked him to call to see her and made an appointment for him the next day. A further ECG was not considered necessary. Examination revealed tenderness in the lower back region. A full set of observations were not recorded and no further investigations were considered necessary. On 16th April 2017 the deceased called for an ambulance and was taken the Royal Stoke University Hospital with ongoing back pains. He was subsequently found to have L1 fracture and transverse process fractures L2-L4, healing left 11th and 12th rib fractures and bi-basal consolation. He was treated for pneumonia and a spinal abscess was drained. He deteriorated and died in the Royal Stoke University Hospital on 29th June 2017. A post mortem examination gave the cause of death as bronchopneumonia, osteomyelitis of the spine and traumatic spinal fracture. The conclusion at the inquest was that the deceased died from an accidental fall. He had been examined by clinicians but his injuries remained undiagnosed for a two week period. -

4	**CIRCUMSTANCES OF THE DEATH** Reason: fall with multiple fractures.
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) The deceased attended A&E on the 4th April 2017.He had a very significant head injury 10 cm long requiring 15 stiches and exposing the skull. He had fallen downstairs. He gave a history of a fall from 4 steps. He complained of back and neck pain. Examination of the spine did not reveal any tenderness and other observations were within normal parameters. Further investigations were considered unnecessary and the NICE guidelines were considered. . The deceased's presenting condition appeared to fall within a grey area/borderline decision warranting further investigation by way of x-ray/scan. A decision was made not to do this. He later died from injuries sustained in that fall. It is understood that nationally work may be underway to reduce the threshold in such borderline cases. It may be of benefit to future patients for this matter to be further considered. (2) Mr Worthington persistently complained of back pain. He saw his GP on the 13th April 2017. He was tender on his back. No further investigation was recommended and a full set of observations were not taken or not recorded. He presented to the hospital 3 days later with irreversible bronchopneumonia. A full set of observations may have given an earlier indication of the developing problem .

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Dr Verso and the Royal Stoke University Hospital 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 **24th August 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:- 1. [redacted] (daughter of the deceased) 2. Stoke-on-Trent Clinical Commissioning Group Smithfield One Building, Stoke-on-Trent ST1 4FA 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	28/06/2018 Signature_____ Margaret J Jones HM Assistant Coroner **Stoke-on-Trent & North Staffordshire**