	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: University Hospital Birmingham NHS Foundation Trust**
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
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 27/11/2018 I commenced an investigation into the death of Ronald William Lowe. The investigation concluded at the end of an inquest on 2nd April 2019. The conclusion of the inquest was a narrative conclusion that 'Death due to a delay in treatment of complications of elective surgery'.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased collapsed at home on the 26th October 2018 and was found to be in cardiac arrest, despite transfer to the Good Hope Hospital he could not be resuscitated and died at 11:40. At a review at the Birmingham Chest Clinic on the 7th September 2018 the Deceased had reported increased shortness of breath ever since a knee replacement on the 27th June 2018 and a CT pulmonary angiogram was arranged. Pulmonary embolus was identifiable from the CT scan but anticoagulation was not started as there was a five week delay in reporting it owing to a combination of individual and systemic omissions. With prompt commencement of anticoagulation it is likely Mr. Lowe would have survived. Following a post mortem the medical cause of death was determined to be: 1a) PULMONARY EMBOLISM 1b) TOTAL KNEE REPLACEMENT SURGERY
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. Investigations have identified that there is no evidence that the radiographer, [redacted], who undertook [redacted] scan on the 20th September 2018 had seen the standard operating procedures for CT applicable in September 2018. 2. It was [redacted] evidence that he had not seen these SOPs. 3. [redacted] has now had additional training on PE and been provided with updated SOPs which he has signed and has been through his training records with the CT Lead to ensure that he has seen, and it is evidence that he has seen, all applicable SOPs and training. 4. The evidence of [redacted], Consultant Radiologist at QEH who conducted the RCA, was that all radiographers have now been provided with and required to sign the updated CT SOPs but there has been no audit or review of radiographs files to check that other aspects of their training are documented and up to date. 5. I am concerned that it had previously gone unnoticed that [redacted] had not signed a copy of the SOPs for CT indicating that there is not a robust system for ensuring radiographers have

	seen all standard operating procedures relevant to their practice. Consequently there is a risk that radiographers are practicing with an incorrect understanding of their duties and obligations which could endanger life. 6. It was the evidence of [redacted] that the radiographers are managed differently at QEH to those at GHH, therefore this report is directed at the training records of radiographers at the former Heart of England NHS Foundation Trust Hospitals, being Good Hope Hospital, Birmingham Heartlands Hospital and Solihull Hospital.
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 29 May 2019. 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 family of Mr. Lowe. 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	03/04/2019 Signature  Emma Brown Area Coroner **Birmingham and Solihull**