REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am Nicola Jones, assistant coroner, for the coroner area of North Wales (East and Central)]
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 29 July 2015 I commenced an investigation into the death of Mrs Mary Myfanwy Hollands, aged 98. The investigation concluded at the end of the Inquest on 3 December 2015. The conclusion of the Inquest was that Mrs Hollands died from natural causes. The medical cause of death was I(a) Ischaemic Heart disease , Pneumonia. II Old Age, Dementia.
4	**CIRCUMSTANCES OF THE DEATH** (1) Mrs Hollands was a 98 year old lady with dementia. She sustained an unwitnessed fall at the nursing home where she lived and was transported to Ysbyty Gwynedd by ambulance. She complained of pain in her left shoulder and left hip. X rays where taken of the shoulder and hip. Both of these were examined and the junior doctor who reviewed the x ray of the hip could not see any bony injury. It was believed that Mrs Hollands was suffering from a UTI and she was given antibiotics. Mrs Hollands was transferred to the medical team and was subsequently discharged. (2) She then deteriorated over the next four weeks and washer less mobile than before the fall. She was admitted by ambulance to Ysbyty Glan Clwyd on 10 July 2015. As well as treating Mrs Hollands for dehydration and an infection an xray was taken of her left hip. This revealed a bony injury. Whilst this could not be dated it was confirmed that the result was the same as the xray taken four weeks earlier. The bony injury had been missed on the previous occasion at Ysbyty Glan Clwyd. Mrs Hollands was not strong enough for surgical intervention and she was discharged with advice that the hip injury be managed conservatively. Mrs Hollands continued to deteriorate and died on 27 July 2015 It is accepted that the hip injury was very difficult to identify. In these circumstances there is a safety netting system in place. A radiologist considers the X-ray and does a report within 48 hours which is sent to the Emergency Department. In Mrs Hollands' case the Consultant Radiologist reported that there was "a step in the cortex of the medial It neck raising the possibility of an undisplaced fracture. If there are ongoing

	symptoms, then a repeat film with a lateral is recommended." The paper copy of this report never arrived in the Emergency Department. By the time the report was signed off Mrs Hollands had been discharged. The Emergency Department were not alerted to the possibility of the fracture. Whilst the report was put on the PACS system there was no prompt for the Emergency Department staff to consider this.
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:- (1) The system currently in place for radiologist's reports being passed to the Emergency Department is not sufficiently reliable or safe so as to provide effective safety netting for patients. (2) Under the current system the x ray will be put on the PACS system and any obvious bony injury will have the words "red dot" typed on the area of the injury. The Emergency Department doctor must analyse all X-rays to check for an injury, whether or not marked with "red dot". This is then followed with a radiologists report within 48 hours. The report is put on the PACS system and a paper copy is despatched to the Emergency Department and attached to the notes. The radiologist will in his report note any injuries which he has seen. This provides a safety net where an Emergency Department doctor may have missed a more subtle injury so that a patient, whom has been discharged can be recalled for future advice and/or treatment. (3) There is currently no coding system for radiologists to make those reports which identify injuries easily identifiable so that the busy Emergency Department can prioritise the reading of those reports with a view to recalling patients whose injuries have gone undetected. This is in the context of some 50000 patients passing through each Emergency Department each year, an average of one third of whom are x rayed . Time is currently being wasted in an already busy department ploughing through reports which do not need to be considered as no injury is disclosed. (4) Also the method of passing the paper information to the Emergency Department is flawed. There are regular occasions when the paper report does not arrive, as happened in the case of Mrs Hollands, meaning that some patients are not recalled for necessary advice and treatment, as in the case of Mrs Hollands. Once the paper report arrives in the Emergency Department the paper notes have to be located and the Paper report attached before it can be considered in context. On occasion a radiologist will come down and discuss a report. There appears to be a lack of consistency (5) There needs to be a reliable system for the report of the radiologist to be delivered to the Emergency Department, prioritising patient's with injuries. An optimum system could be devised between senior Consultant Radiologists and Senior Consultant Emergency doctors. This needs to be considered for use prior to digitalisation of Emergency Department notes and incorporated into the anticipated digitalised system.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 15th February 2016 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, [redacted] Next of Kin) 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	**[DATE] 21st December 2015 [SIGNED BY ASSISTANT CORONER]**