IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Rainer Wickens
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Chief Executive - St George's Healthcare NHS Trust**
1	**CORONER** Martin Fleming ADC Surrey
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 17/9/12 Mr Richard Travers Senior Coroner for Surrey, opened an inquest into the death of **Rainer Wickens** who, at the date of his deaths was aged 59 years. The jury inquest was resumed on 28/4/14 and concluded on 2/5/14 The jury found that the cause of death to be: - 1a. Pulmonary Thrombo-Embolism 1b. Deep Vein Thrombosis II Fracture of the Thoracic Spine (Operated) The jury found a narrative conclusion
4	**CIRCUMSTANCES OF THE DEATH** On the morning of 3/9/12, Mr Wickens fell through the roof of the single storey rear extension to 28 Yew Tree Road, whilst in the process of assisting in its demolition as part of his employment. As a consequence of the fall, paramedics were called and he was taken to St George's Hospital, where he was found to have sustained a fracture to his thoracic spine. The fracture was stabilised as a result of surgery carried out on 5/9/12. During his admission to hospital there were episodes where his blood oxygen saturations gave cause for concern. During his subsequent post operative intensive care, a decision was made by his treating doctors

	for tests to exclude the formation of a Pulmonary Embolism. Doctors requested the test on the morning of 6/9/12, the day after his operation, but Mr Wickens suffered a cardiac arrest and died before the tests were made in the late afternoon of the same day.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter that gave rise to concern and which, in my opinion, there is a risk that future deaths could occur by reason thereof unless action is taken. The **MATTER OF CONCERN** is as follows. – • Although Mr Wickens was at risk of clot formation, he remained untreated for clot formation for 10 hours in A&E • Gaps in the medical notes • Poor verbal communication at handovers between treating doctors • Breakdown in communication between junior doctor and radiologist resulting in avoidable delay of CTPA • Delay in commencement of inquiry of the SUI report and the impact of the delay on remedial action re impact on patient treatment I would be grateful if you could re consider the appropriateness of allowing such vulnerable and unsupervised residents access to the stairs given the potential for serious injury.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that St George's Health Care, NHS Trust have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to:

	• [redacted] • [redacted] (KP Warne Builders) • Chief Coroner
9	**DATED this 20st May 20014**