REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Matthew Hopkins, Barking, Havering & Redbridge University Hospitals NHS Trust. Executive Offices, Queens Hospital, Rom Valley Way, Romford, Essex, RM7 0AG.**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the area of Eastern District of Greater London
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/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The investigation into the death of Mr Pether commenced on the and concluded following the Inquest hearing on the 2 October 2014. The outcome of the Inquest was a narrative conclusion: Mr Pether sustained a punctate right peri-prosthetic fracture of his right femur, in a fall sustained at his home on the 8 December 2012. There was a delay in surgical intervention due to a lack of beds at the tertiary centre and a norovirus outbreak on the ward. The wound was found to be septic and necrotic on the 20 December 2012. Despite an above knee amputation performed on the 21 December 2012 and intensive care, Mr Pether developed multi-organ failure culminating in left ventricular failure from which he died.
4	**CIRCUMSTANCES OF THE DEATH** Mr Pether was admitted to Queen's Hospital on the 8 December 2012 following a fall. A right femur peri-prosthetic fracture was diagnosed upon admission. It was also noted at this time that he had a low grade infection in his right knee prosthesis. There was a raised risk of him developing an infection in his right limb fracture due to the fact that it was an open fracture; there was a pre-existing infection around the site of the wound and the patient was on immuno-suppressant medication. The treatment plan agreed was for a complex surgical reconstruction to take place at the RNOH in Stanmore. It was agreed by the Consultant Orthopaedic Surgeon in charge of Mr Pether's care that surgery should take place as quickly as possible following an open fracture. One reason for this is to avoid infection. Unfortunately – the transfer did not take place due to lack of beds at the tertiary centre and then a norovirus outbreak on the ward. The Consultant Orthopaedic Surgeon confirmed that there should have been daily checks of the viability of the wound by the medical staff. The Matron confirmed that there should have been two daily checks of the viability of the limb by the nursing staff. The limb was found by the Medical Registrar to be infected on the 20 December 2012. There was a necrotic and septic wound of 3cm x 3cm down to the bone. The ITU consultant who assessed Mr Pether that day informed the family of the clear source of infection in the leg; the possibility of pneumonia and an acute kidney injury. His

	prognosis at this stage was very poor. Despite surgery and intensive care, Mr Pether continued to deteriorate and died on the 30 December 2012. The cause of death was: 1a Left ventricular failure; 1b coronary artery atheroma and hypertension; 2 infected right femur peri-prosthetic fracture; right above knee amputation for fracture; pneumonia.
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. Despite the clear risk of infection in Mr Pether's wound there were no medical record entries by the orthopaedic medical team or nursing team on Amber ward, of any focussed checks upon the viability of Mr Pether's limb between the 11 December and the 20 December 2012. This would appear to be a very basic standard of care required on an orthopaedic ward. 2. Between the 11 December and the 20 December 2012 the only medical entries for plan of care related to the fact that Mr Pether was "awaiting Stanmore". There is no evidence of any discussion as to the effect of this significant delay in the provision of treatment and whether the options for his treatment should have been re-considered. 3. By the 19 December 2012, there was a raised CRP and evidence of an acute kidney injury. It is certainly arguable that a more detailed assessment of the patient at that time and a re-consideration of options by the orthopaedic team should have taken place at that time. 4. Even on the 20 December 2012 when Mr Pether's clinical condition significantly deteriorated (acute kidney injury and chest infection now clearly manifesting), the orthopaedic team failed to identify the source of the infection. It would appear that it was the family that raised concerns about Mr Pether's breathlessness which led to a review by the Medical Registrar. The Medical Registrar carried out a very full assessment and identified the likely source of sepsis in the right leg. She involved the microbiology team and requested a review by ITU and the orthopaedic registrar. After this time, Mr Pether received a good standard of care, but at this stage, his prognosis was very poor.
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 the 1 December 2014. 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] (son of the deceased) and the Care Quality Commission, 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	**[DATE]** **[SIGNED BY CORONER]**