

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used after an inquest.*

<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>RE: IAN WILLIAM REID, Deceased</b>  <b>THIS REPORT IS BEING SENT TO:</b></p> <p>1. The Rt. Hon. Jeremy Hunt MP          Secretary of State for Health          Richmond House          79 Whitehall          LONDON SW1A 2NS</p> <p><b>CORONER</b></p> <p>I am David Llewelyn Roberts, senior coroner, for the coroner area of North and West Cumbria</p>	<p>1</p>
<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>	<p>2</p>
<p><b>INVESTIGATION and INQUEST</b></p> <p>On 4<sup>th</sup> September 2013 I commenced an investigation into the death of Ian William Reid, age 77 years. The investigation concluded at the end of the inquest on 23<sup>rd</sup> June 2014. The conclusion of the inquest was: Cause: (a) Bronchopneumonia; (b) Periprosthetic fractured left neck of femur; II Idiopathic progressive peripheral neuropathy, ischaemic heart disease. Conclusion: Accident.</p>	<p>3</p>
<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On the 24<sup>th</sup> July 2013 at his home address at [REDACTED] Penrith, the deceased fell backwards. As a result of the fall he fractured the site of a previous left hip repair. He was admitted to the Cumberland Infirmary that day. There was a delay in the hip revision surgery due to the need to source the necessary components. The operation on the 29<sup>th</sup> July was technically successful. The deceased had, however, developed pneumonia overnight prior to the surgery. Post operatively he remained in intensive care and notwithstanding treatment failed to thrive and died on 27<sup>th</sup> August 2013.</p>	<p>4</p>
<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>The deceased had a hip repair operation some years before the fall on the 24<sup>th</sup> July. On his admission to hospital in 2013 it was not known what type, manufacture or</p>	<p>5</p>

<p>specification his hip implants were. The hospital which carried out the original surgery could not provide the information. Part of the lapse of time prior to corrective surgery was due to the hospital trying to establish the specification to ensure the correct components were available at the revision surgery. During this period the deceased developed pneumonia. Unnecessary delay can increase the risks for patients in these circumstances.</p> <p>Might action be taken to enable individual patients to have a formal document confirming all the necessary details of the implant so this information could be readily available should there be a further fracture. Could there be a system to ensure that hospitals do have a clear accessible record which could be passed onto the surgeon who will carry out the revision.</p>	<p><b>6</b></p> <p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</p>	<p><b>7</b></p> <p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 26<sup>th</sup> August 2014. I, the coroner, may extend the period.</p> <p>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.</p>	<p><b>8</b></p> <p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following interested Persons:</p> <p>[REDACTED]</p> <p>North Cumbria University Hospitals NHS Trust</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>	<p><b>9</b></p> <p><b>DATE:</b> 30/6/14</p> <p><b>SIGNED:</b> [Signature]</p>
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