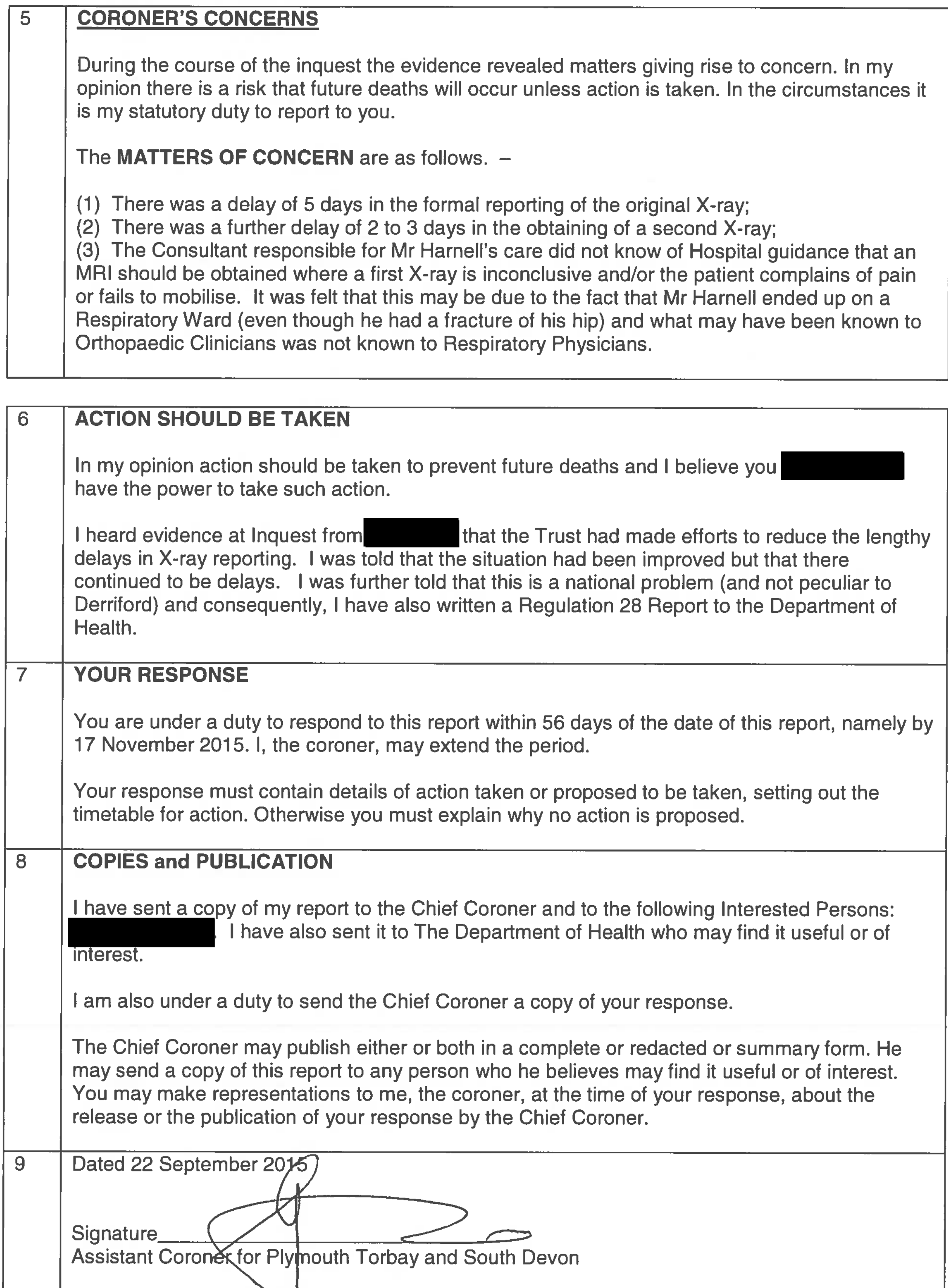
ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Medical Director Plymouth Hospitals NHS Trust Derriford Road Plymouth PL6 8DH
1	**CORONER** I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 15/12/2014 I commenced an investigation into the death of William John Charles Harnell then aged 67. The investigation concluded at the end of the inquest on 15 September 2015. The conclusion of the inquest was that Mr Harnell died as the result of an accident. He had suffered a fractured left neck of femur while attempting to mobilise from his wheelchair in the early hours of 22 October 2014. The cause of death was given as: 1 (a) Hospital Acquired Pneumonia; 1 (b) Left Hip Fracture; II Cerebral Vascular Event and left sided weakness.
4	**CIRCUMSTANCES OF THE DEATH** Mr Harnell was seen in the emergency department at 04.47 hours on 22 October 2014. An X-ray of his left hip was performed at 05.34 hours. This was interpreted as being "not conclusive so it needs either repeat film with better analgesia/MRI to exclude fracture". Mr Harnell was admitted to the Medical Assessment Unit and from there on to Honeyford Ward where he came under the care of [redacted] The X-ray was not formally reported until 27 October 2014 (5 days after admission). The report noted that "the left hip is markedly rotated making interpretation difficult. There is no evidence of a fracture. If there is ongoing clinical concern then a repeat X-ray is recommended". Mr Harnell was re-examined on 28 October when he was found to have a good range of pain free movement. On 29 October, however, the physiotherapy team noted that he was complaining of left hip pain and a repeat X-ray of the hip was requested. This did not take place until 2 November and was not reported until 3 November when an impacted fracture of the left neck of femur was demonstrated. On 3 November it was decided that Mr Harnell should have non-operative management of his fractured hip with pain relief and mobilisation as tolerated. While he was fit for discharge from 4 or 5 November, Mr Harnell remained in Hospital until he developed Pneumonia and died on 15 December 2014. It was not clear from the evidence I heard that the initial delay in reporting the first X-ray and the subsequent delay in organising an the reporting of the second X-ray caused Mr Harnell's death

3 The Crescent, Plymouth, PL1 3AB
Tel 01752 204 636 | Fax 01752 313297



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) There was a delay of 5 days in the formal reporting of the original X-ray;
(2) There was a further delay of 2 to 3 days in the obtaining of a second X-ray;
(3) The Consultant responsible for Mr Harnell's care did not know of Hospital guidance that an MRI should be obtained where a first X-ray is inconclusive and/or the patient complains of pain or fails to mobilise. It was felt that this may be due to the fact that Mr Harnell ended up on a Respiratory Ward (even though he had a fracture of his hip) and what may have been known to Orthopaedic Clinicians was not known to Respiratory Physicians.

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.

I heard evidence at Inquest from that the Trust had made efforts to reduce the lengthy delays in X-ray reporting. I was told that the situation had been improved but that there continued to be delays. I was further told that this is a national problem (and not peculiar to Derriford) and consequently, I have also written a Regulation 28 Report to the Department of Health.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 November 2015. 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: . I have also sent it to The Department of Health 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 Dated 22 September 2015

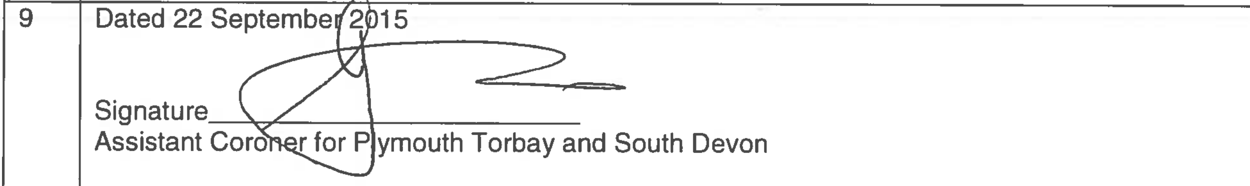
Signature_______________________________________
Assistant Coroner for Plymouth Torbay and South Devon

3 The Crescent, Plymouth, PL1 3AB
Tel 01752 204 636 | Fax 01752 313297

ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr J Hunt MP** Secretary Of State For Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 15/12/2014 I commenced an investigation into the death of William John Charles Harnell then aged 67. The investigation concluded at the end of the inquest on 15 September 2015. The conclusion of the inquest was that Mr Harnell died as the result of an accident. He had suffered a fractured left neck of femur while attempting to mobilise from his wheelchair in the early hours of 22 October 2014. The cause of death was given as: 1 (a) Hospital Acquired Pneumonia; 1 (b) Left Hip Fracture; II Cerebral Vascular Event and left sided weakness.
4	**CIRCUMSTANCES OF THE DEATH** Mr Harnell was seen in the emergency department at 04.47 hours on 22 October 2014. An X-ray of his left hip was performed at 05.34 hours. This was interpreted as being "not conclusive so it needs either repeat film with better analgesia/MRI to exclude fracture". Mr Harnell was admitted to the Medical Assessment Unit and from there on to Honeyford Ward where he came under the care of [redacted] The X-ray was not formally reported until 27 October 2014 (5 days after admission). The report noted that "the left hip is markedly rotated making interpretation difficult. There is no evidence of a fracture. If there is ongoing clinical concern then a repeat X-ray is recommended". Mr Harnell was re-examined on 28 October when he was found to have a good range of pain free movement. On 29 October, however, the physiotherapy team noted that he was complaining of left hip pain and a repeat X-ray of the hip was requested. This did not take place until 2 November and was not reported until 3 November when an impacted fracture of the left neck of femur was demonstrated. On 3 November it was decided that Mr Harnell should have non-operative management of his fractured hip with pain relief and mobilisation as tolerated. While he was fit for discharge from 4 or 5 November, Mr Harnell remained in Hospital until he developed Pneumonia and died on 15 December 2014. It was not clear from the evidence I heard that the initial delay in reporting the first X-ray and the subsequent delay in organising and the reporting of the second X-ray caused Mr Harnell's death

3 The Crescent, Plymouth, PL1 3AB
Tel 01752 204 636 \| Fax 01752 313297

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) I heard evidence during the course of the Inquest that delays in the reporting of X-rays are not peculiar to Plymouth Hospitals NHS Trust but are a National problem. I was further told that this is as a consequence of a lack of qualified Radiologists to complete the reports. (2) (3)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Mr J Hunt MP have the power to take such action. It is plainly undesirable for a patient not to have a conclusive diagnosis from X-ray of a fractured hip for 10 days following admission into Hospital.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 November 2015. 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: I have also sent it to Medical Director, Plymouth Hospitals NHS Trust 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	Dated 22 September 2015  Signature____________________ Assistant Coroner for Plymouth Torbay and South Devon

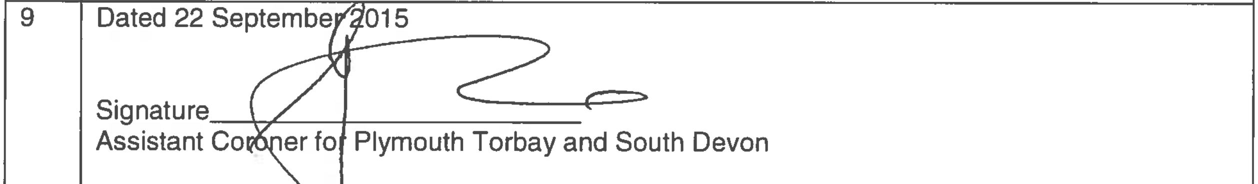
3 The Crescent, Plymouth, PL1 3AB
Tel 01752 204 636 | Fax 01752 313297

ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Director Of Social Services County Hall Truro Cornwall
1	**CORONER** I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 15/12/2014 I commenced an investigation into the death of William John Charles Harnell then aged 67. The investigation concluded at the end of the inquest on 15 September 2015. The conclusion of the inquest was that Mr Harnell died as the result of an accident. He had suffered a fractured left neck of femur while attempting to mobilise from his wheelchair in the early hours of 22 October 2014. The cause of death was given as: 1 (a) Hospital Acquired Pneumonia; 1 (b) Left Hip Fracture; II Cerebral Vascular Event and left sided weakness.
4	**CIRCUMSTANCES OF THE DEATH** Mr Harnell was admitted to Hospital on 22 October. The fracture of his hip was not diagnosed until 3 November. I have already written to Plymouth Hospitals NHS Trust to raise concerns in this regard. At Inquest I was told that Mr Harnell was fit to be considered for discharge from approximately 4 November 2014. Subsequently, he had chest pain which required investigation and may have delayed matters by approximately a week. By the middle of November, however, Mr Harnell was ready for discharge. Regrettably, Mr Harnell was not discharged and remained in Hospital until he developed Pneumonia and died on 15 December 2014 approximately one month later. I heard evidence at Inquest that part of the reason why Mr Harnell continued to remain in Hospital was that he presented as an extremely challenging patient. He was, on occasions verbally and physically abusive to staff. It was not immediately clear whether this was due to a mental health condition or a personality defect. I heard evidence that, but for this behaviour, Mr Harnell would have been discharged to a Community Hospital. That option was not available, however, and neither was a return to his home address given the decision to treat the hip fracture conservatively, It seems clear from the evidence that by the middle of November it was plain Mr Harnell could only be discharged to a nursing Home of some sort. It was not, however, until 28 November when I understand [redacted] the Social Worker involved rang five homes that may be able to offer this sort of facility

3 The Crescent, Plymouth, PL1 3AB
Tel 01752 204 636 | Fax 01752 313297

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) There was delay in recognising that Mr Harnell was a most challenging patient for whom the usual means of discharge would not all be available. (2) There appears to have been delay in determining Mr Harnell's state of mental health (3) There appears to have been delay in approaching the Nursing Homes that may have been able to accommodate him. (4) There appears to be a lack of resources available for dealing with challenging (and vulnerable) patients like Mr Harnell. (5) There appears to be no guideline or protocol to assist staff on how best to deal with the discharge of patients like Mr Harnell.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 17 November 2015. 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 Mr [redacted] I have also sent it to [redacted] Medical Director Plymouth Hospitals NHS Trust and Mr J Hunt MP 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	Dated 22 September 2015  Signature____________________ Assistant Coroner for Plymouth Torbay and South Devon