C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Executive Director** **BMI The Shelburne Hospital** **Queen Alexandra Road** **High Wycombe** **Bucks HP11 2TR**
1	**CORONER** I am **CRISPIN GILES BUTLER**, Senior Coroner for Buckinghamshire
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 16th May 2016 I commenced an investigation into the death of Stephen John Bird, aged 51 . The investigation concluded at the end of the inquest on 21st July 2016. The medical cause of death was recorded as:- 1a Pulmonary Embolism 1b Deep Vein Thrombosis 1c Recent Surgery for Achilles Tendon Injury The narrative conclusion recorded was as follows:- Mr Bird underwent surgery at the Shelburne Hospital on 6th May 2016. Prior to the procedure he had been assessed as being at a high risk of Venous Thromboembolism (VTE) and this was recorded in the medical notes. Mr Bird was re-assessed subsequently and considered to be a low risk of VTE. Pharmacological VTE prophylaxis was not prescribed. A mechanical VTE prophylaxis regime was prescribed. Mr Bird died at his home address during the afternoon of 11th May 2016. Mr Bird's death resulted from a risk of the surgical procedure.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bird had an elective operation on the 6th May 2016 at the Shelburne BMI hospital High Wycombe for an achilles tendon injury. The procedure appeared to go well and he was discharged the same day with Codeine as pain killers and thrombo embolus deterrent

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	stockings. On the 11th May 2016 Mr Bird's partner left the house approximately 0800hrs. She spoke with Mr Bird at midday and all appeared normal. He was found at 1830hrs by the partner's daughter collapsed unresponsive on the floor next to his bed at his home address. Paramedics attended but Mr Bird was declared deceased at his home address. He was taken to Wexham Park Hospital where a post mortem examination was carried out and the described medical cause of death identified. Further investigations with the Shelburne revealed that Mr Bird was not prescribed anti-coagulation but was given an exercise regime upon discharge. The key facts established during the Inquest were recorded in a brief, neutral narrative conclusion.
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 patient records, the documentation of consultations, clinical decisions, changes to previous assessment decisions and the discharge records were incomplete, inconsistent and/or conflicting and this was acknowledged during the Inquest hearing. (2) Evidence given regarding the investigation by the hospital into Mr Bird's death and the preparation of a draft Significant Clinical Incident Investigation (SCII) Report (disclosed as part of the Inquest process) identified an assumption of facts within that draft report which conflicted with documentary records and this was acknowledged during the Inquest hearing. It was indicated during the hearing that the hospital places reliance upon SCII reports as part of a learning process.

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 16th September 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**

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	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- The Bird Family [redacted] Consultant, The Shelburne [redacted] Consultant Anaesthetist, The Shelburne [redacted] Director of Nursing & Quality, The Shelburne I have also sent a copy of this report to the Group Executive Director, BMI Healthcare House, 3 Paris Gardens, Southwark, London SE1 8ND 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 July 2016 Signature_____ Senior Coroner for Buckinghamshire

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