REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 23 MARCH 2017 IS BEING SENT TO:** **Judith Paget, Chief Executive,** **Aneurin Bevan University Health Board** Headquarters St Cadoc's Hospital Lodge Road Caerleon Newport NP18 3XQ
1	**CORONER** I am Philip Charles SPINNEY, Area Coroner, for the coroner area of South Wales Central.
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.
3	**INVESTIGATION and INQUEST** On 25 January 2017 I agreed to conduct an investigation into the death of Patricia Yvonne Donovan. The investigation concluded at the end of the inquest on the 22 March 2017. The conclusion of the inquest was a narrative conclusion as follows: *Patricia Yvonne Donovan was given a general anaesthetic in preparation for total hip replacement surgery. She suffered an unforeseen adverse drug reaction that led to acute cardiac failure.*
4	**CIRCUMSTANCES OF THE DEATH** Patricia Yvonne Donovan was admitted to the Royal Gwent Hospital on 12 January 2016 following a fall in which she sustained a fractured neck of femur. It was decided to treat her by total hip replacement. On 19 January 2016 Mrs Donovan was given a general anaesthetic in preparation for surgery. Shortly after anaesthesia was induced she suffered an adverse reaction to the anaesthetic agent that caused cardiac failure and her death.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows.

	A decision was made for Mrs Donovan to receive total hip replacement as she was able to walk independently of aids prior to her fall. This decision was in accordance with National Institute for Health and Care Excellence (NICE) guidelines. Mrs Donovan was listed for surgery on 14 January 2017; due to insufficient theatre staff the operation was cancelled and it was rescheduled for the following day. The following day the operation was cancelled due to resource availability. The next available opportunity for surgery with a specialist surgeon was 19 January 2017 (7 days after the fall). NICE guidelines state that treatment of neck of femur fractures should be within 48 hours but recognise that in certain circumstances, it may be appropriate to delay for the correct operation by the correct specialist. Evidence was given at the inquest that ideally surgery should be completed in 3 to 4 days. It is acknowledged that in this case, there were competing priorities on resources and surgery was arranged for the first available list with an appropriate specialist. It is also acknowledged that the delay in surgery did not have an impact on Mrs Donovan's cause of death; however, it is recognised that serious complications leading to potentially life threatening conditions can arise where prompt surgery is not undertaken.
6	**ACTION SHOULD BE TAKEN** **A review of the procedures in respect of the provision of emergency surgery for trauma patients where specialist skills are needed. The review should consider rescheduling elective cases and redeploying specialist staff if necessary.** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 **18 May 2017**. 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 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	**SIGNED:** **Mr Philip Spinney** **HM Area Coroner**