REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, New Cross Hospital NHS Trust.** **2. Chief Executive, Wolverhampton City Council**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 28 December 2018, I commenced an investigation into the death of Mrs Elsa Reid. The investigation concluded at the end of the inquest on 8 March 2019. The conclusion of the inquest was a short form conclusion of accidental death. The cause of death was: 1a **Pulmonary Embolism** b **Left Femur Fracture-Open Reduction and Internal Fixation** c **Fall** II **Urinary Sepsis, Hypertension, Type 2 Diabetes Mellitus, Cerebrovascular Accident**
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Reid was a 92 year old woman who was admitted to New Cross Hospital on the 30 October 2018 after a fall at home and sustained a complex fractured hip. This was surgically repaired in Hospital and post operatively she made adequate recovery. ii) Whilst in Hospital, she was given physiotherapy and encouraged to increase her mobility with an exercise regime. The purpose of the latter treatment was designed to reduce risks associated with immobility including the development of a pulmonary embolism. iii) She was later discharged on the 30 November 2018 to Eversleigh Care Home which acts as step-down temporary facility to allow rehabilitation. iv) There was some conflicting information provided upon discharge on whether she should be hoisted and allowed to sit in a chair and frequency of mobility exercises. Specifically, the occupational therapist sent an email to the Consultant in charge on the 11 December (some 12 days after discharge) to clarify the conflicting information regarding weight bearing or non-weight bearing and whether the patient needs hoisting. The consultant

	responded by stating that she shouldn't be hoisted. v) On the 19 December her condition declined rapidly and she was re-admitted to the same hospital. vi) Sadly she died after developing a pulmonary embolism on the 20 December 2018.
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. Evidence emerged during the inquest that there was inadequate communication between the Hospital and occupational therapist to resolve the issue in a timely manner which resulted in a minimal exercise/mobility regime being implemented. 2. Although it is recognised some bed bound exercises were completed there was insufficient urgency amongst those professionals involved to resolve the matter as quickly as possible and thereby reduce the risks of complications, including pulmonary embolism from developing.
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. 1. The Hospital Trust in conjunction with Wolverhampton City Council may wish to consider urgently reviewing the protocols in place during discharge of patients to step-down care. In particular, the information provided during the discharge process and contacting the lead Consultant where clarity is needed.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 May 2019. 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; Family. 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	**2 April 2019** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**