ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Royal Orthopaedic Hospital**
1	**CORONER** I am Andrew Cox, Assistant Coroner, for the coroner area of Worcestershire
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 17th February 2015 I commenced an investigation into the death of Bryan Arnold CATANACH then aged 84. The investigation concluded at the end of the inquest on 26 November 2015. The narrative conclusion of the inquest was that Mr Catanach died as the result of an accident. It is possible that a subsequent fall out of bed while attempting to go to the toilet may have contributed. It is also possible a failed attempt at traction may have contributed to the death. The medical cause of death was 1(a) respiratory failure, 1(b) cervical spinal cord injury, 1(c) Fractured odontoid peg sustained in a fall.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 11.00am on 3rd February 2015 Mr Catanach fell after attending his local gym. He suffered a serious neck injury, sustaining a fracture dislocation of the odontoid peg with tearing of the posterior atlanto occipital ligament. He was taken to Worcestershire Royal Hospital. An x-ray confirmed the injury and he was referred to the Royal Orthopaedic Hospital at approximately 20.00hrs. In the evening of 4th December 2015, Mr Catanach was seen by a consultant from Royal Orthopaedic Hospital who deemed him fit for operative treatment and transfer. Instructions were left for the transfer to be effected by 08.00am on 5th February 2015. This did not happen Mr Catanach being transferred by about 11.30am. Shortly after admission into Royal Orthopaedic Hospital Mr Catanach, having been told to stay immobile on bed rest, attempted to get up probably to use the toilet. He fell. Instructions were left for senior review to take place that afternoon. That did not happen until after 20.00hrs. Mr Catanach's condition was found to have deteriorated at review and he was fitted with a halo crown later that night with traction applied. The appropriate traction equipment could not be found and an inferior alternative was used. On 6th February 2015 a pulley wheel was found to be jammed rendering the traction ineffective. The halo crown had to be replaced. On 7th February 2015 the correct traction equipment was found, assembled and applied. On 8th February 2015 Mr Catanach's condition deteriorated and he died in the hospital shortly after 14.00hrs.

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 were a number of difficulties with communication between the various clinicians and hospital Trusts. This led to a delay in the initial transfer of the patient, a delay in his subsequent review by a senior clinician and confusion on the part of nursing staff as to whether Mr Catanach was to be kept nil by mouth and/or given his prescribed medication. While it is a matter for you it may be that the Trust will want to reflect on whether there is a need to standardize its inter-hospital transfer process so that nursing as well as medical staff are fully engaged with the process.

(2) Additional concerns over communication were identified with clear instructions from Consultants not being carried out. In particular, an instruction to have the deceased transferred to the Royal Orthopaedic Hospital before 08:00 hours on 5th February 2015 was cancelled (on the wrong basis that no spare bed was available) and the cancellation of the transfer was not communicated back to the consultant. Additionally, an instruction by the consultant to a junior doctor directing his Registrar to review Mr Catanach was only partly acted upon. This led to a delay in the senior review of Mr Catanach which, when it took place 9 hours after admission, recognised a deterioration in his condition.

It is a matter for the Trust to reflect on how best to ensure that Consultants' instructions are fully acted upon and where, for whatever reason, that proves impossible, the situation is communicated back to the Consultant concerned.

(3) Almost immediately after his admission into the Royal Orthopaedic Hospital with a fractured dislocation of this neck Mr Catanach fell out of this hospital bed. This was probably due to him attempting to get up to use the toilet. Mr Catanach's fall took place even though two members of the nursing staff had expressly told Mr Catanach not to move and provided him with a buzzer through which to seek nursing assistance if required.

Mr Newton-Ede, having reflected upon the matter, felt that similar patients in the future may be better protected by a transfer into the HDU rather than a standard ward.

The Trust may wish to reflect on whether this is a realistic alternative. If implemented this change will need to be audited to see whether there are sufficient resources available within HDU. If not, an alternative course of action considered at inquest was that for the small number of patients admitted with an unstable neck fracture it may be appropriate immediately to arrange one to one nursing care pending operative fixation of the fracture.

(4) Traction equipment - Mr Catanach had a halo crown fitted in an attempt to reduce the fracture he had suffered. At the time this was undertaken Mr Newton-Ede did not have available to him the required Balkan beam traction equipment and a Swan neck device was used instead. This was plainly inferior and indeed a pulley wheel was found to have jammed the following morning rendering the traction ineffective and causing the fracture to slip back.

It took 48 hours for the correct traction equipment to be found. It was likely that the equipment was available the whole time but that either staff did not know where it was kept, or those sent to find it did not know for what they were looking.

It is a matter for the Trust to reflect on how to remedy this situation. It would seem that training of relevant staff would be a sensible first step.

(5) I heard evidence at the inquest that there was no safe and effective way of a patient in traction to have a CT scan without the traction weights being released. While I was told that only a small number of patients will require both traction and a CT scan it maybe that the Trust considers that this is something that should be considered further.

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 25th January 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** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons being Mrs Catanach and Mr Newton Ede. 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** ---------- **1st day of December 2015**