REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive, Bolton NHS Foundation Trust, Trust Headquarters, Royal Bolton Hospital, Minerva Road, Bolton BL4 0JR.
1	**CORONER** I am CATHERINE CUNDY, assistant coroner, for the coroner area of MANCHESTER WEST.
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 [the details below are fictional]** On the 28TH of JUNE 2021 I commenced an investigation into the death of JOAN WRIGHT, aged 91. The investigation concluded at the end of the inquest on 15 DECEMBER 2021. The conclusion of the inquest was a narrative, namely that the deceased died as a consequence of severe infection which developed in her hip following necessary surgery to treat a left fractured neck of femur. During surgery a guide wire penetrated her pelvis which is a rare though recognised complication of dynamic hip screw fixation. It is unclear whether earlier recognition of the source of infection would have improved her chances of survival. The medical cause of death was 1a Sepsis; 1b Infected wound on left hip (post dynamic his screw fixation for traumatic fracture of the left femur).
4	**CIRCUMSTANCES OF THE DEATH** On the 27th of February 2021 the deceased fell at her home address. She was admitted to the Royal Bolton Hospital the same day and diagnosed with a fractured left neck of femur. She underwent dynamic hip screw fixation on the 28th of February 2021, during which a guide wire was noted to have advanced through the pelvis and into the abdomen. No record was made of this complication in the operation note and the occurrence was not flagged with medical or nursing staff or with the deceased's family. On the 9th of March 2021, a blood test showed the deceased had a raised marker of infection. While the infection marker dipped slightly on the 10th of March 2021, it remained high thereafter. On the 19th of March 2021 the wound discharged a high volume of purulent fluid which contained coliform bacteria. On the balance of probabilities this infection was introduced into the wound by the guide wire which had penetrated her pelvis during surgery. The deceased underwent two surgical washouts of the wound on the 19th and the 22nd of March 2021and was commenced on antibiotics. It was not until this point that the wider treating team became aware of the guide wire penetration that had occurred on the 28th of February 2021. The deceased remained an in-patient at the hospital until the 30th of April 2021 when she was discharged to a nursing home on intravenous antibiotics. Following a deterioration in her condition she was readmitted to the Royal Bolton Hospital as an emergency on the 30th of May 2021 where she was treated for suspected pneumonia before being discharged again to the nursing home on the 9th of June 2021. Her condition continued to deteriorate and she died at the nursing home on the 16th of June 2021.
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 could 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) Both the Divisional Review Report produced by the Trust and oral evidence at the inquest disclosed problems with insufficient workable IT facilities at the hospital to allow for timely record-keeping in patients' electronic notes. I was advised that all clinical staff are supposed to make records in the electronic notes and that no handwritten records are now kept. I heard evidence that staff therefore have to rely on memory, or notes written on scraps of paper, until such time as they can access the electronic records on a computer. This case provided several instances in the care of a single patient where either no notes were made at all of clinical discussions or management plans, or crucial information was omitted. I am concerned that the issues of availability, workability and accessibility of IT equipment for such recording (in the context of a reliance on paperless working) creates a risk of future deaths to other patients where crucial information may go unrecorded.
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 11th FEBRARY 2021. 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 - the deceased's son and daughter. 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	C. P. Cundy **17 DECEMBER 2021** **CATHERINE CUNDY**