

Newcastle upon Tyne Coroners MRS KAREN L DILKS HM SENIOR CORONER

Civic Centre, Barras Bridge, Newcastle Upon Tyne, NE1 8QH

Date: 7 December 2022

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: CORONER

I am Carly Henley for Newcastle and North Tyneside Coroners 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

INVESTIGATION and INQUEST

On 10 May 2022 I commenced an investigation into the death of Joan Alison FERGUSON. The investigation concluded at the end of the inquest. The conclusion of the inquest was

Joan Alison FERGUSON died at the Royal Victoria infirmary, Newcastle upon Tyne on 5th May 2022 of acute chronic congestive cardiac failure due to biventricular cardiac hypertrophy and an open fracture of her left tibia/fibula and distal femur. She had been discharged home following a short hospital admission at North Tyneside General Hospital. She had super morbid obesity and required ambulance transfer.

- During transfer on 3rd May 2022, she fell in the ambulance and sustained an open fracture 3 to her tibia/fibula and a fractured left femur requiring surgical repair which was carried out the same day. She did not survive the consequences of her injuries in light of her comorbidities.
 - 1a Acute on Chronic Cardiorespiratory Failure
 - 1b Biventricular Cardiac Hypertrophy and Open Fracture of Left Tibia/Fibula and Distal Femur (operated on 03/05/22)

1c

II Morbid Obesity, Type 2 Diabetes Mellitus, Hypertension, Cor Pulmonale, Mitral Stenosis and Liver Cirrhosis

CIRCUMSTANCES OF THE DEATH

64yr female

Recent NTGH admission with constipation, AKI and increasing oxygen requirements was being discharged home falling getting out of ambulance (DNACPR in place)

open right tib/fib+distal femur #

Significant Co-morbidity

- 1. Super Morbid Obesity ~130kg
- 2. OHS/ OSA CPAP intolerant, possible COPD, Home Oxygen
- 3. AF, HTN, Pul HT RV dilation severe biatrial dilatation, mitral stenosis (2019)
- 4. DM

Family attended ED as probable un-survivable injury given co-morbidity

Theatre GA and splinting of # with tibial nail and femoral retrograde nail, for analgesia and as open #

L3 post op ventilated on high CVS support Nad/Ad

Following morning woke and extubated onto HFNC, unfortunately no sig improvement in CVS support

Deteriorated overnight with retained secretions, respiratory distress

Fentanyl started

Family attended and HFNC / pressor stopped

Discussion with paramedics transport team Deborah (Investigating), Coroners

Family very happy with care at RVI and opportunity to have time with Joan

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.

5 The **MATTERS OF CONCERN** are as follows. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

- (1)
- (2)
- (3)

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner

⁸ 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.

7 December 2022

9 Signature Limeley

Carly Henley Assistant Coroner for Newcastle upon Tyne Coroners