MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care [redacted] 2. [redacted] CEO Barking, Havering and Redbridge University Hospitals NHS Trust
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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**

	On 1 December 2022 I commenced an investigation into the death of John Edward Stiff. The investigation concluded at the end of the inquest on the 5 April 2023. The conclusion of the inquest was that Mr Stiff died as a result of an accident (following a fall).
4	**CIRCUMSTANCES OF THE DEATH** On the 10 November 2022, Mr. Stiff was admitted to Queen's Hospital having suffered a believed unwitnessed fall. In Queen's Hospital, he was diagnosed as suffering from an undisplaced fracture of the pelvis. A decision was taken to treat Mr. Stiff conservatively. Even though there was no surgical intervention, he was admitted under the care of the orthopaedic team. The orthopaedic team are not specialists in controlling medical problems associated with fractures. During the course of the admission, Mr. Stiff's appetite was much reduced. He was not offered any nutritional supplements. On the 15 November 2022 he had reduced oxygen saturations and the medical team became involved in his care. He was diagnosed as suffering from a chest infection. He was treated with supplemental oxygen; intravenous fluids and intravenous antibiotics. Sadly, Mr. Stiff did not recover and he passed away at Queen's Hospital on the 16 November 2022. It is likely that the fall and fractured pelvis on the 10 November 2022 caused a decline in health and mobility which would have contributed to the development of the fatal pneumonia.
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: The Inquest heard evidence from an orthopaedic surgeon that patients such as Mr Stiff, who suffer hip and pelvic fractures and who have a number of additional age-related co-morbidities, would be best cared for by ortho-geriatricians. The inquest heard that this matter has been raised by the orthopaedic team on multiple occasions, but the orthogeriatric provision has not been increased. The Inquest also heard that the lack of orthogeriatric provision is a national issue of concern within the NHS. Orthopaedic trauma in elderly patients often exacerbates underlying medical conditions. Orthogeriatric trained staff would be better trained to recognise and treat medical co-morbidities. It is therefore considered that improved access to orthogeriatric care for this patient cohort could prevent future untimely deaths.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 **13 June 2023**. 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 to the Inquest, family of Mr Stiff, to the Care Quality Commission and to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**18 April 2023**