Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO: -** **University Hospitals of Derby and Burton NHS FT** **Derbyshire Community Health Services NHS FT** **East Midlands Ambulance Service**
1	**CORONER** I am Peter Nieto, Area Coroner for the coroner area of Derby and Derbyshire.
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 05 July 2021 I commenced an investigation into the death of Alice Jean FOX aged 90. The investigation concluded at the end of the inquest on 26 May 2023. The conclusion of the inquest was that: Mrs Alice Jean Fox, known as Jean, died in hospital on 1 July 2021 due to the effects of severe infection resulting from bacterial infection of her surgical site in relation to a partial hip replacement for fracture following a fall at home.
4	**CIRCUMSTANCES OF THE DEATH** Jean was admitted to Royal Derby Hospital on 7 June 2021 following her fall, and surgery was performed on 9 June. There were no complications during the surgery nor in her post-operative care leading to discharge to Ripley Rehabilitation Hospital where she arrived at about 23:00 on 22 June. Because she arrived so late and out of core hours, she did not have the benefit of the full and usual assessments and she had also been waiting for the transfer for some significant time at the general hospital in its discharge lounge. The rehabilitation hospital nurse who examined Jean on her arrival noticed the wound site to be red and hot to touch and considered there was a possibility of infection and it was thereafter kept under visual observation. The following morning an advanced nurse practitioner requested routine blood samples be taken as part of the clinical assessment and the blood samples were taken the next day, 24 June, and were available for clinical review that afternoon but were not reviewed until the next day, 25 June, when raised inflammatory markers were noted and Jean was then transferred back to the general hospital (Royal Derby Hospital) due to infection. At the general hospital antibiotic treatment was started but Jean was not considered fit to undergo major surgery to remove the partial hip replacement and wash out the wound and end of life care was agreed with her family. Although the court considered that there had been opportunity to refer Jean back to the general hospital earlier, on the evidence this would not have prevented her death, as even at

	that earlier point surgery would not have been appropriate due to the high risk of mortality given her comorbidities and frailty.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. Jean had spent a lengthy period in the general hospital discharge lounge, during which time which she would not have had close checks and observations as compared to ward-based care. She did not arrive at the rehabilitation hospital until late at night and so did not have the usual core admission assessments. Such situations appear to me to have the potential to place patients such as Jean at significant risk. Given that there would usually be three parties involved in the transfer (the discharging hospital, the transporting ambulance service, and the discharge destination) there is opportunity for consideration of protocols to ensure such discharge arrangements are safe and appropriate. 2. Jean had signs of infection to the surgical site on arrival at the rehabilitation hospital and should have had more robust clinical review but confirmation of infection and referral back to the general hospital did not occur until her blood results were reviewed 3 days later. There had been opportunity to expedite the blood results. On the evidence at inquest there is reason to think that the rehabilitation staff were falsely reassured by a low NEWS score whereas there was suspected infection that could have been confirmed earlier.
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 August 04, 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:- [redacted] (daughter of Jean Fox) [redacted] (son of Jean Fox) University Hospitals of Derby and Burton NHS FT Derbyshire Community Health Services NHS FT I have also sent it to the Care Quality Commission 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 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 by the Chief Coroner.
9	**Dated: 09/06/2023**  **Peter Nieto** **Area Coroner for Derby and Derbyshire**