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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1) [redacted], Chief Executive, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester WR5 1DD |
| 1 | **CORONER**<br><br>I am David Donald William REID, HM Senior Coroner for Worcestershire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br><br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 24 July 2023 I commenced an investigation and opened an inquest into the death of Terence Edward Hines. The investigation concluded at the end of the inquest on 14 December 2023.<br><br>The conclusion of the inquest was that Mr. Hines "died as the result of a bacterial infection of a recent surgical wound. His death was contributed to by neglect." |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>In answer to the questions "when, where and how did Mr. Hines come by his death?", I recorded as follows:<br><br>*"*On 30.6.23 Mr. Hines, who had recently sustained a fractured right neck of femur following a fall whilst an inpatient in the Alexandra Hospital, Redditch, was admitted to Worcestershire Royal Hospital and underwent surgery there to fix the fracture the following day. A few days later his surgical wound became infected with the bacteria methicillin-resistant staphylococcus aureus ( MRSA ). Despite treatment, including surgical debridement and washout of the infected wound, his condition continued to deteriorate, and he died in hospital on 15.7.23. Investigations confirmed that he had picked up the MRSA bacteria because his room at the Alexandra Hospital, which had previously been occupied by another patient with MRSA, had not been cleaned in accordance with hospital policy." |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>In the course of the inquest, I found the following facts to have been established:<br>1) Mr. Hines had been admitted to the Alexandra Hospital on 26.5.23, where he was treated for a ruptured Baker's cyst;<br>2) On 19.6.23 Mr. Hines was moved to side room 2, on ward 2 at the hospital. This room had been vacated that same day by another patient who had had a |

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| | known MRSA infection and an exfoliating skin condition which, taken together, represented a heightened risk of a subsequent occupant of the room developing an MRSA infection, and therefore ought to have triggered a Red ( hydrogen peroxide ) clean of the room before Mr. Hines moved into it;<br>3) A Red clean of the room did not take place before Mr. Hines moved into the room – instead, an Amber ( chlorine ) clean was carried out in error;<br>4) The Trust's investigation into the circumstances surrounding Mr. Hines' death was unable to establish why no Red clean was ordered, or why an Amber clean had been mistakenly ordered instead;<br>5) On or about 24.6.23, because Mr. Hines had now been an inpatient for 28 days, he should have been screened for MRSA. That routine MRSA screen was not carried out. The Trust's investigation was unable to explain why that routine screen had not been carried out;<br>6) On 26.6.23 Mr. Hines suffered an accidental fall in the room, and was found to have sustained a fractured right neck of femur. As a result, he was transferred to Worcestershire Royal Hospital where surgery to fix the neck of femur fracture was carried out on 1.7.23;<br>7) As a matter of established routine, Mr. Hines should again have been screened for MRSA prior to his surgery,. Once again, that routine MRSA screen was not carried out. The Trust's investigation did not explore the question of why that routine MRSA screen had not taken place;<br>8) Mr. Hines was eventually screened for MRSA on 3.7.23 ( after his surgery ), and a couple of days later the results of that screen confirmed that he had tested positive for MRSA. He was started on decolonisation treatment on 6.7.23;<br>9) A few days after his surgery, Mr. Hines developed an infection around his surgical wound, and sepsis. He was returned to theatre on 12.7.23 for debridement and washout of the surgical wound. Analysis of swabs from the wound and blood cultures, both taken during this procedure, showed the presence of MRSA, and that the MRSA matched that of the previous occupant of his side room at the Alexandra Hospital;<br>10) Despite treatment, Mr. Hines died at Worcestershire Royal Hospital on 15.7.23. The cause of death was:<br>1a sepsis;<br>1b infected surgical wound ( methicillin-resistant staphylococcus aureus );<br>2 heart failure and chronic kidney disease;<br>11) Had side room 2 on ward 2 at the Alexandra Hospital received the required Red clean before Mr. Hines moved into it, he would probably not have developed the MRSA infection, and would probably not have died when he did.<br><br>Although I was unable to be satisfied, on the balance of probabilities, that identification of the MRSA infection at either the missed routine 28 day screen on or about 24.6.23, or at the missed pre-surgery screen on 1.7.23, would have resulted in treatment which would likely have prevented Mr. Hines' death, it is a matter of grave concern that these screens and the Red clean of the room, all routine measures designed to identify, treat and prevent the spread of such a serious pathogen, were not carried out.<br><br>These failures have led me to conclude that staff at both the Alexandra Hospital, Redditch, and Worcestershire Royal Hospital, do not have sufficient awareness of the Trust's policies and procedures which require such measures to be taken. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of Worcestershire Acute Hospitals Trust, have the power to take such action. |

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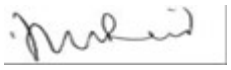
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **9 February 2024.** I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following:<br><br>(a) [redacted] ( Mr. Hines' brother ).<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **15 December 2023**<br><br>  <br><br>**David REID**<br>**HM Senior Coroner for Worcestershire** |