M. E. Voisin
His Majesty's Senior Coroner
Area of Avon

28th February 2024 [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **North Bristol Trust**
1	**CORONER** I am Dr Simon Fox KC, Assistant Coroner for **Area of Avon.**
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 20/12/22 an investigation was commenced into the death of Gillian Baumgardt. The investigation concluded at the end of the inquest on 27th February 2024. The conclusion of the inquest was – **"Mrs Baumgardt died in part because she underwent wrong site hip surgery due to multiple errors occurring in the performing and reporting of a plain x-ray of her hip".**
4	**CIRCUMSTANCES OF THE DEATH** Mrs Baumgardt was an elderly lady with dementia who fractured her right hip at home. She was admitted to your hospital and diagnosed correctly with a suspected fractured right hip. However, in then performing and reporting the plain x-ray of her hips the following errors occurred – Radiographer – - Pre-exposure marker not placed in film field; - Digital image inadvertently flipped; - Digital image mislabelled left/right so that fractured side recorded as left; - Cross on image denoting flipped not detected; - Normal x-ray of left hip did not alert to error and did not lead to the affected side being double checked; Radiologist – - Normal x-ray of left hip attributed to error in labelling, rather than alerting to error and leading to the affected side being double checked.

	As a result Mrs Baumgardt was referred to the orthopaedic team erroneously as presenting with a left hip fracture. Her age and dementia were such that she was difficult to assess clinically, the orthopaedic surgeons had no reason to suspect an error in labelling and she underwent surgery removing a healthy left femoral head. The error was then appreciated and she had to undergo surgery to the right fractured hip 2 days later. She died 6 weeks later having never regained her mobility. I found on the evidence that the wrong site surgery contributed to her death.
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 will 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)Accurate radiology is essential to avoid wrong site surgery in elderly patients with dementia suffering hip fracture; (2) There is no system requiring radiographers to ensure that pre-exposure markers are present in the x-ray field in all such patients; (3) There is no system requiring radiologists to investigate inconsistency in the site of injury between different images and to alert clinicians to the inconsistency before finalising their report in all such patients.

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 26th April 2024. 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 Mrs Baumgardt's family. 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	28/02/2024  Dr Simon Fox KC, Assistant Coroner **Area of Avon.**