MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

[redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Rotherham NHS Foundation Trust

1. CORONER

I am Louise Slater, Area Coroner for South Yorkshire East

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 3 August 2023 I commenced an investigation into the death of Anne HAWKES. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Narrative conclusion.

Mrs Hawkes died in Rotherham District General Hospital on the 15th July 2023 as a consequences of multi organ dysfunction due to an infected hip joint. The infection occurred due to surgical wound breakdown because of pressure caused by fluid overload as a result of poorly managed cardiac failure.

4. CIRCUMSTANCES OF THE DEATH

Mrs Hawkes was admitted to Rotherham Hospital on the 3rd of May 2023 following a fall at home. She had sustained a fracture neck of femur and underwent surgical fixation the following day. Mrs Hawkes initially recovered well and was medically fit for discharge by the 11th of May 2023. Mrs Hawkes remained on the orthopaedic ward whilst awaiting social care input prior to discharge. Whilst on the orthopaedic ward, her cardiac failure was not monitored by way of fluid balance charts or daily weights. Her weight on admission had been estimated at 72 kilogrammes, by the 22nd May 2023, her weight had increased to 104.5 kilogrammes.

This increase in weight was not acted upon until the 17th of May 2023 when a referral to cardiology was made, by this time she was very unwell with fluid retention, hyponatremia and deteriorating renal function. Mrs Hawkes was seen by specialist Cardiac failure nurses on the the 22nd May and immediately commenced on intravenous medication to deal with this fluid excess. Mrs Hawkes was

transferred to the cardiology ward on the 25th of May 2023.

Whilst on the cardiology ward her weight gradually reduced to 83 kilogrammes. On the 26th June 2023, she was considered stable in relation to her cardiac failure. On the 3rd of June 2023 the surgical wound started to break down. All witnesses at the inquest agreed that the wound breakdown was most likely due to this fluid overload putting pressure on the wound causing it to breakdown. There was no evidence of infection in or around the wound out this time.

Despite the wound starting to break down on the 3rd of June, the referral to tissue viability was not made until the 29th of June 2023. By this time, tissue viability were unable to assist due to the advanced state of dehiscence and they made a referral to the orthopaedic surgeons. A surgical washout was declined by Mrs Hawkes, therefore the wound was managed with dressings and antibiotics. She deteriorated and died on the 15th of July 2023.

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) The delayed cardiology referral whilst Mrs Hawkes was on an orthopaedic ward led to sub-optimal management of her cardiac failure which in turn is implicated in her death. There is no procedure in place at the Trust for Clinicians to automatically refer in-patients with known cardiac failure to cardiology for expert management.

(2) T he lack of communication between services within the Trust (surgery, cardiology and tissue viability) led to a delayed and incohesive approach to the wound management.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 the **28th May 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 the following Interested Persons: [redacted]

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. Signature

for South Yorkshire East

2nd April 2024