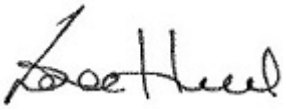
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Royal Orthopaedic Hospital NHS Foundation Trust
1	**CORONER** I am Louise Hunt for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 22 August 2024 I commenced an investigation into the death of Michael John THOMPSON. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Died from a recognised complication of necessary surgery for chondrosarcoma
4	**CIRCUMSTANCES OF THE DEATH** Mr Thompson was found to have an extensive chondrosarcoma of the pelvis. He was admitted to the Royal Orthopaedic hospital on 05/04/24 and had a right sided hindquarter amputation and soft tissue reconstruction on 08/04/24. This was complex surgery involving two consultant orthopaedic oncology surgeons and plastic surgeons. During the surgery a defect was made in the peritoneum during resection of the tumour which was repaired with sutures and bleeding was controlled from the internal iliac vein. There was damage to the contralateral common iliac vein likely caused by dissection during the surgery. This vein injury was difficult to control and required surgeons to attend from University Hospital Birmingham who repaired the defect with a synthetic vascular graft. The surgery was completed and as he was unstable Mr Thompson was transferred to the Queen Elizabeth Hospital ITU for 4 days for resuscitation and closer monitoring. He returned to the Royal orthopaedic hospital on 12/04/24 and appeared to be making good recovery. He developed hiccups overnight on 15/16th April which were treated medically with a plan to arrange a CT scan if this did not resolve. In the early hours of 18/04/24 he sadly collapsed having had a large vomit and should not be resuscitated. Post-mortem examination found a defect in the peritoneum through which small bowel had become herniated leading to vomiting and aspiration. Following a post mortem the medical cause of death was determined to be: **1a ASPIRATION** **1b INTERNAL HERNIA WITH SMALL BOWEL EXTENDING THROUGH A DEFECT IN THE PERITONEUM INTO THE SURGICAL BED** **1c HINDQUARTER AMPUTATION FOR CHONDROSARCOMA** **1d** **II**
5	**<u>CORONER'S CONCERNS</u>**

	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. During the surgery on 08/04/24 a defect was made in the peritoneum whilst dissecting this away from the tumour and the defect was repaired with sutures. The operation note did not record this complication and other staff were unaware of it. This raises a concern about the adequacy of record keeping in the Trust as a key aspect of the patient's surgery was not recorded. 2. Under the PSIRF process a PSII investigation was undertaken however this only dealt with resuscitation efforts and did not address the peritoneal defect and its repair which was the root cause of Mr Thompson's death. This raises a concern about the adequacy of investigations being undertaken by the Trust and their ability to learn from deaths.
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 31 January 2025. 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: Mr Thompson's family I have also sent it to the Medical Examiner, ICS, NHS England, CQC, who may find it useful or of interest. 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	**6 December 2024** Signature: 

	Louise Hunt **Senior Coroner for Birmingham and Solihull**