REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **1.** The British Orthopaedic Association 2. Managing Director of Stryker (UK) Ltd
1	CORONER I am Richard T Middleton, Assistant Coroner, for the Coroner Area of Dorset
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 the 14th December 2023, an investigation was commenced into the death of Reginal Victor Smith, born on the 11th June 1933. The investigation concluded at the end of the Inquest on the 10th January 2025. The Medical Cause of Death was: 1a Hypovolemic Shock 1b Re operation of fractured neck of femur 1c Fractured neck of femur II The conclusion of the Inquest recorded that Reginald Victor Smith died as a consequence of a rare but recognised complication of a surgical procedure.
4	CIRCUMSTANCES OF THE DEATH On 9/10/23 Mr Smith had a witnessed fall at his care home. He was admitted to Poole Hospital where he underwent surgery to repair a right extra capsular neck of femur fracture on 12/10/23. The surgery involved Mr Smith being laid on a traction table and a jig was used to align the fracture for screws to be inserted into a titanium nail which is placed into the femur.

	On 24/10/23 he was discharged from hospital. On 5/12/23 he attended Poole Hospital for a review appointment when X rays disclosed a failure of metalwork inserted on 12/10/23 and he was readmitted to hospital. On 7/12/23 Mr Smith underwent revision surgery. It was apparent that the hip screw was slightly off centre and being approximately 1mm-2mm off centre did not make proper contact with the nail. Following surgery his health deteriorated. Mr Smith received palliative care and he died in hospital on 7/12/23.
5	<u>CORONER'S CONCERNS</u> The MATTERS OF CONCERN are as follows: 1) During the inquest evidence was heard that: i) Evidence was given to suggest there were two probable reasons for the hip screw not correctly passing into the nail: firstly, before the femoral nail and jig were inserted it may be that the jig was loose and needed tightening or secondly, the jig used might have been slightly bent 2) I have concerns with regard to the following: i) Each jig is used many times in surgery having been sterilised after each procedure. It is hammered into the thigh bone and on this occasion may have become deformed over time. ii) The jig was sent away to the manufacturer for analysis but was lost and so no information was available to the court in relation to its integrity. iii) There is no quality control in place in relation to the examination of the jigs being used (other than when it is assembled in theatre by a nurse) prior to surgery. There is no auditing/ spot checks in relation to the integrity of the jigs.

6	ACTION SHOULD BE TAKEN In my opinion urgent 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, by 18th March 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: (1) Mr Smith'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	Dated 21st January 2025	Signed Richard T Middleton