

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: Chief Executive Oxford University Hospitals NHS Foundation Trust
1	CORONER I am Nicholas Graham, HM Area Coroner for Oxfordshire, c/o Oxfordshire Coroner's Office, 1 Tidmarsh Lane, Oxford OX1 1NS
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 6 February 2024 I commenced an investigation into the death of Beryl Dandridge, aged 83. The investigation concluded at the end of the inquest on 10 June 2024. The conclusion of the inquest was a Narrative Conclusion: <i>'On the 23 January 2024 Beryl Dandridge had a fall at her nursing home injuring her hip. An ambulance was called but due to demand it took over 12 hours to attend. She was taken to the John Radcliffe Hospital, Oxford and it was identified that she had suffered a periprosthetic fracture. She was originally listed for surgery on the 25 January, but other cases took priority. She was then re-scheduled for surgery on the 26 January, but this was postponed as it was considered she needed an echocardiogram to assess the potentially fatal risk of surgery. Her surgery took place on the 27 January. Following surgery her condition deteriorated and she died on the 28 January 2024. There is insufficient evidence to establish whether the combined delay in her admission to hospital and in undergoing surgery contributed to her death.'</i>
4	CIRCUMSTANCES OF THE DEATH Please see the Narrative Conclusion in paragraph 3 above which outlines the circumstances. Upon arrival at the hospital, medical staff noted Mrs Dandridge's high heart rate, which was attributed to atrial fibrillation. She underwent surgery for her fractured femur on 27 January, after delays due to theatre capacity issues and differing opinions among medical staff regarding the necessity of a pre-operative echocardiogram. Mrs Dandridge's condition deteriorated after surgery, and she died the following morning. There were concerns raised about the delays in her surgery and the arrangements for expediting an echocardiogram. A Structured Mortality Review was undertaken on the 7 February 2024 which was critical of the anaesthetist's decision to require an echocardiogram prior to surgery and the lack of expedition.

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 could 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. As part of the evidence, it became clear there were conflicting views between clinicians regarding the need for an echocardiogram for vulnerable patients pending periprosthetic surgery and the circumstances when surgery might be appropriately delayed pending such a scan. Evidence was heard that the Anaesthetists of Great Britain and Ireland (AAGBI) guidelines regarding echocardiograms (which apply to hip surgery more generally) were incorrectly applied to the circumstances of Mrs Dandridge's periprosthetic fracture. 2. Having determined that an echocardiogram was required before surgery could take place, it was unclear which clinicians was responsible for expediting such a scan in circumstances where the evidence indicated that delays in surgery is associated with poorer outcomes for vulnerable patients. 3. The Structured Mortality Review was critical of the decision to require an echocardiogram pending surgery. Such a review is designed to provide learning for the Trust to be applied in future cases. The evidence at the Inquest was that the Review had no input from an anaesthetist who may have articulated the medical justification for such an echocardiogram in this instance. Concerns were raised in evidence that without the relevant subject expertise at such Reviews any future learning from a Structured Mortality Review could be inaccurate or misconceived. You should consider a review of your procedures relating to the arrangements for echocardiograms and to the conduct of structured mortality reviews.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 6 August 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 Dandridge's family. I have also sent it to Dr Joanne Cudlipp, who was an Interested Person, who may find it useful or of interest. I have also sent a copy to the Berkshire, Buckinghamshire and Oxfordshire Integrated Care Board. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	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.
9	12 June 2024 