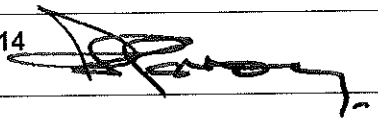
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **North Bristol NHS Trust** 2. **Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner 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.
3	**INVESTIGATION and INQUEST** On 9th July 2013 I commenced an investigation into the death of Mr Robert Anthony Perkins age 69 years. The investigation concluded at the end of the inquest on 21st March 2014. The conclusion of the inquest was that the medical cause of death was I(a) Metastatic bladder cancer; II Vertebral Fracture, Fall and the short-form conclusion was that the death was due 'Natural Causes'.

4	**CIRCUMSTANCES OF THE DEATH** Mr. Perkins was admitted to the Emergency Department of Frenchay Hospital on 5th June 2013 where he arrived at around 12:30 hours. He suffered with terminal cancer and had suffered a fall at home that morning. He was confused, agitated and complaining of posterior neck pain. On examination he had a large focal swelling over C4 - C6 with tenderness. A CT scan showed that he had suffered a compression fracture of C5 with marked angulation. Advice was sought from the neurosurgeons who considered that in the context of his terminal cancer with poor prognosis the fitting of a Philadelphia neck collar would be the appropriate sole treatment. It was noted that Mr. Perkins was due to be admitted to a hospice for terminal care. However, a bed was not immediately available at the hospice and Mr. Perkins was admitted to the ward overnight. Despite the instructions of the neurosurgeons no collar was fitted. Mr. Perkins was seen that evening by the consultant on the post-take ward round and he was seen again the following morning, the 6th June 2013, when still no collar had been fitted. That same morning Mr. Perkins was discharged to the hospice. He was seen by the Specialist Registrar in Medicine being escorted in a wheel chair by ambulance personnel. The Registrar, who in evidence, stated he had not seen Mr. Perkins before identified that Mr. Perkins should have a collar fitted and he was returned to the ward. The Registrar, who had neurosurgical experience, considered it to be unsafe for Mr. Perkins to be transferred without wearing a collar and decided to fit one as had been instructed by the neurosurgeons. There was no collar available on the ward and the Registrar spent some time visiting other wards and departments to obtain a Philadelphia collar but could not locate one in the hospital. Eventually he obtained a Miami J Collar and with assistance this collar was fitted and Mr. Perkins discharged to the hospice. When Mr. Perkins arrived at the hospice it was discovered that one part of the collar may have been fitted incorrectly causing him discomfort and it was removed. Mr. Perkins remained at the hospice where he died on 16th June 2013
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) Notwithstanding the instructions of the neurosurgeons no effort was made to obtain and fit a cervical collar throughout the time he was on the ward. It was fortuitous that the patient did not suffer neurological injury. However, he was at risk of serious injury and death as a consequence of the failure to immobilise the neck. (3) Other than the Specialist Registrar no concerns were raised by medical staff that the patient's neck was not properly immobilised both on the ward and on discharge. (4) The hospital is a regional centre for neurosciences and neurosurgery yet the prescribed cervical collar was not available and the Registrar had difficulty locating a suitable collar. (5) The failure to properly immobilise the neck of patients with fractures of the cervical spine, whether on the instructions of neurosurgeons or otherwise, could place those patients at risk of significant and disabling injury and death.
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 23rd June 2014. 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. 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	**28th April 2014**  **Assistant Coroner**