ANNEX A

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:** **The Chief Executive,** **North Lincolnshire and Goole Hospitals NHS Trust,** **Diana, Princess of Wales Hospital,** **Scartho Road,** **Grimsby, DN33 2BA** **N.E. Lincs.**
1	**CORONER** Paul Kelly, Senior Coroner for the area of North Lincolnshire and Grimsby
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** Inquests conducted on 25th September 2014 at Scunthorpe (Maurice Cowling deceased) 3rd February 2015 at Cleethorpes (Leonard Ireland deceased) and 5th March 2015 at Cleethorpes (Robert Connon deceased) concluded the deaths in each case were connected directly or indirectly to hemiathroplasty.
4	**CIRCUMSTANCES OF THE DEATH** In the cases of the late Mr. Cowling and Mr. Connon the deaths occurred as the direct result of the procedure. In the case of the late Mr. Ireland death occurred later as the result of complications arising from the procedure.
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. – Despite evidence of the rarity of deaths occurring as a consequence of such procedures three cases have received the attention of the Coroner within a short period. Two procedures were carried out within the Trust, the third (Mr. Connon) by St Hugh's Hospital under an NHS contract. In the latter case the deceased was transferred to a Trust hospital for emergency management.

	Evidence led in the cases raise concerns that resources within the Trust area may be inadequate to deal with recognised complications occurring either during the procedure or later
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. Namely, a patient safety review (if necessary in conjunction with other providers of like services to the NHS) in respect of hip replacement surgery to include, but not limited to, the adequacy of local services to deal with complications.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th May 2015. I 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, namely families of the deceased in each case 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	**13th March 2015.** **H.M. Senior Coroner**