	H M Coroner, London Inner South REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[REDACTED] - Acting Chief Executive, King's College Hospital, Denmark Hill, London SE5 9RS**
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South
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	**INQUEST** On 11th May 2015, I opened an inquest into the death of: **Rosina Drury, who died on 21st October 2013 in Kings College Hospital, Case Ref: [REDACTED]** Her medical cause of death was: 1a fat embolism 1b Bone cement implantation II Fractured right femur (operated). It was concluded that she died of unintended consequences of necessary medical treatment.
4	**CIRCUMSTANCES OF THE DEATH** Evidence was heard that: The deceased had ischaemic heart disease (a myocardial infarct in 2009), atrial fibrillation (on Warfarin), hypertension, recently recovered chest infection and diabetes, but she was fit and although unsteady, independent. She fell, fracturing her hip. A right hemiarthroplasty was chosen and she died of a rare complication. Evidence was heard from the consultant orthopaedic surgeon that uncemented arthroplasties, that avoid fatalities from bone cement implantation, although an embolus is still possible), achieve less good pain control, result in slower mobilization and have a higher mortality at 30 days. The surgeon said that he did not choose the uncemented technique unless the patient was immobile. This remained the position even if there was a history of pulmonary embolus. The expert opinion read, from [REDACTED] identified that good practice in prevention was pre-operative review within four hours of admission by an orthogeriatrician, to assess and manage multiple co-morbidities. This did not happen in this case and only occurs if the surgeon considers a referral was needed. It was also heard from scientific literature that bone cement implantation should be avoided in high risk cases. She was reviewed prior to surgery by a consultant anaesthetist with appropriate seniority, another of [REDACTED] recommendations.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter, 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. – Does not having a pre-operative orthogeriatric review, recommended by an expert, risk that patients with high risk co-morbidities sometimes have a cemented hemiarthroplasty, when an uncemented one would avoid mortality from bone cement implantation, for which there is no curative treatment and can be fatal? It is suggested that KCH NHS Foundation Trust may wish to review arrangements for pre-operative review of patients with sub-capital fractured neck of femur requiring fixation with a hemiarthroplasty.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Trust 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 Wednesday, 25th November 2015. 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. If you require any further information or assistance about the case, please contact the case officer,
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: nephew, FRCS, consultant orthopaedic surgeon, Consultant Orthopaedic Surgeon. I have also sent a copy to President of Royal College of Surgeons, and the Rt. Hon Jeremy Hunt MP Secretary of State for Health. 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	**[DATE]** 2nd October **[SIGNED BY CORONER]**