REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive NHS Foundation Trust (Walsall Manor Hospital)** 2. **Care Quality Commission (CQC).**
1	**CORONER** I am Mr Zafar Siddique, Senior Coroner, for the coroner area of Black Country.
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 23 September 2015, I commenced an investigation into the death of Mr Frank Mellers (dob 18/9/21). The investigation concluded at the end of the inquest on 17 November 2015. The conclusion of the inquest was a narrative conclusion: Mr Mellers had a fall at home on the 4 September 2015 and sustained a fractured left hip. He was admitted to Hospital the same day and had an operation to repair the fracture on the 16 September 2015. Post operatively he initially made good recovery and a do not attempt resuscitation notice (DNAR) was in place prior to surgery. There were a number of occasions of poor communication with the family of the deceased where little or no explanation was given to the family as to his actual DNAR status. In addition he was thought to be not classified as DNAR by nursing staff and CPR was commenced when his condition declined and he suffered a cardiac arrest on the 17 September 2015. He was initially resuscitated and then had a further heart attack and on this second occasion, CPR was not commenced and he died on the 17 September 2015 as a result of congestive cardiac failure, Ischaemic heart disease contributed to by the stress of the necessary operation to repair the fracture." The medical cause of death was 1a) Congestive cardiac failure 1b) Ischaemic heart disease 1c) Post-operative repair of fracture neck of femur.
4	**CIRCUMSTANCES OF THE DEATH** **The circumstances are apparent from the conclusion outlined above.**
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) Evidence emerging from the inquest suggested that the patient's DNAR status was fixed without any reference to/discussion with his family. It is recognised

	that this is a medical decision for the physician but good practice and guidelines require that the family be kept up to date with all such decisions. (2) There was generally poor communication between nursing and medical staff as evidenced during the inquest when a decision was made to attempt resuscitation despite there being a DNAR in place. (3) In light of the inquest findings, you may consider that the guidelines and policy in the issuing and communication of DNAR may need to be examined.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 January 2016. 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, Mr Meller'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	**17 November 2015**