REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Medway NHS Foundation Trust**
1	**CORONER** I am Patricia Harding, senior coroner for the coroner area of Mid Kent & Medway
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 2nd September 2015 I commenced an investigation into the death of Alwyn Ann Head, 70 years. The investigation concluded at the end of the inquest on 21st March 2016. The conclusion of the inquest was that Alwyn Ann Head died from a recognised complication of a consented and necessary procedure
4	**CIRCUMSTANCES OF THE DEATH** Alwyn Head was admitted to Medway Maritime Hospital on 10th August 2015 following two falls in which she fractured her left femur at the site of a prosthesis which had been previously placed in Belgium following a similar fracture after a fall. She underwent surgery and approx.12 days post-operatively a wound infection was noted which was later determined to be MRSA. She was given antibiotics the following day and two days later underwent a debridement and washout. She deteriorated post-operatively requiring increasing inotropic support. She died on 20th August 2015
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) That Mrs Head had a history of MRSA was not established prior to surgery despite opportunities in 3 different hospital departments to obtain this information from Mrs. Head or her family (2) ProphylacticTeicoplanin was not provided pre- or post-operatively even though the results of an MRSA screen would not have been available at the time of surgery (MRSA –ve written on pre-op form erroneously)

	(3) A post-operative wound care plan was not instituted contrary to NICE guidelines (4) There was no evidence of the surgical wound having been inspected by nursing staff or doctors between 13th August and 25th August 2015 (5) Entries in the nursing notes relating to dressing and wound were meaningless and would not assist a determination of whether there was deterioration in the wound
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 19th May 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 [redacted] Care Quality Commission 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	**23rd March 2016** **[SIGNED BY CORONER]**