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:** **1.** Chief Executive of the Salford Royal Hospital, Eccles Old Road, Salford
1	**CORONER** I am Rachael Clare Griffin, Assistant Coroner, for the Coroner Area of Manchester West
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 the 10th October 2016 I commenced an investigation into the death of Gordon Arthur born on the 3rd September 1941. The investigation concluded at the end of the Inquest on the 25th January 2017. The Medical Cause of Death was: Ia Left Ventricular Hypertrophy due to Aortic Stenosis and Bronchopneumonia II Right Total Hip Replacement The conclusion at the Inquest was that Gordon Arthur died as a consequence of a combination of naturally occurring disease and a recognised complication of elective surgical treatment.
4	**CIRCUMSTANCES OF THE DEATH** On the 18th August 2016 Mr Arthur, who suffered from Left Ventricular Hypertrophy and Aortic Stenosis, underwent a Right Total Hip Replacement at Trafford General Hospital, Trafford and was discharged on the 21st August 2016. On the 31st August 2016 he was treated with antibiotic therapy for a suspected infection at the site of the surgery. On the 6th September 2016 he suffered a cardiac arrest and was admitted to the Salford Royal Hospital, Salford. He was resuscitated and underwent surgery to wash out the surgical site in order to treat the infection. Following this he had further surgery to wash out the site and close the wound on the 11th September 2016. He remained stable until his condition suddenly deteriorated on the 5th October 2016 and he died. Prior to

	the surgery he had been active and mobile, but due to the surgery and subsequent treatment, his mobility significantly deteriorated.
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. During the inquest evidence was heard that: i. The Consultant in charge of Mr Arthur's hip operation, and who carried out the surgery, was [redacted] who is based at Salford Royal NHS Foundation Trust. ii. Following Mr Arthur's discharge from Trafford General Hospital on the 21st August he presented to the Accident and Emergency Department at Salford Royal Hospital on the 25th August as the surgical wound had started to ooze, which can be a sign of infection. At that time an ultrasound scan of his hip was requested and the wound was redressed. [redacted] confirmed the scan should have been done urgently, however it was not carried out until the 1st September. iii. Mr Arthur re-attended the Accident and Emergency department on the following with continued oozing from the surgical wound. The wound was redressed again and he was discharged. iv. [redacted] was not made aware of Mr Arthur's attendance at the Accident and Emergency Department on either the 25th or the 26th August until the 31st August, when he immediately requested that antibiotic therapy be prescribed, which Mr Arthur started taking that night. Had he been made aware of Mr Arthur's condition he would have admitted him on the 25th August for further investigation and treatment. v. The ultrasound scan took place on the 1st September which revealed a collection at the surgical site, again indicative of infection. The radiologists reported the scan but this was never reviewed and [redacted] was not made aware of the results. vi. On the 6th September Mr Arthur was attending his GP for a problem with his shoulder when he suffered a cardiac arrest. Fortunately Doctors were on hand to resuscitate him and he was taken to the Salford Royal Hospital where investigations revealed infection at the surgical site. He underwent surgery to wash out his hip that day. He was actively treated for that infection, which at the time of the post mortem examination had resolved.

	vii. From the evidence given the delay in the treatment of the infection at the site of the hip surgery was not, on the balance of probabilities, causative or contributory to his death. During the evidence [redacted] confirmed that there is no policy in place at the Trust detailing procedures for the request of investigations, such as scans or x-rays, nor is there a policy relating to the notification of the results of such investigations to the Consultant in charge of the patient's care. I have concerns with regard to the following: i. The lack of policies dealing with the process of investigative tests and the notification of their results to Consultants in charge of a patient's care could lead to patients not being given the treatment they require, which could result in a future death. I therefore request that you review the policies and procedures relating to investigative procedures and the reporting of their results to the Consultant in charge of the patient's care in order to prevent a future death.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, 30th March 2017. 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: (1) [redacted] Mr Arthur's wife on behalf of the 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	**Dated** **2nd February 2017**	**Signed** **Rachael C Griffin**