REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Sandwell and West Birmingham Hospitals NHS Trust.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the 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 the 25 April 2017, I commenced an investigation into the death of the late Mrs Lily Townsend. The investigation concluded at the end of the inquest on 12 June 2017. The conclusion of the inquest was a short narrative conclusion of: "Died after developing a rare but recognised complication of pulmonary fat embolism due to bone cement implantation syndrome." The cause of death was: 1a Pulmonary Fat Embolism b Bone Cement Implantation Syndrome c II Ischaemic Heart Disease and Pulmonary Fibrosis
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Townsend had an unwitnessed fall at home in her bathroom on the evening of 11 February 2017 and was admitted to Sandwell Hospital on the 12 February. ii) She had a medical history including cancer, severe cardio pulmonary disease, atrial fibrillation and pulmonary fibrosis. A fractured neck of femur was diagnosed. iii) Inadequate medical history was taken during the preoperative assessment and a failure to record her previous myocardial infarction, ischaemic heart disease and pulmonary hypertension. iv) On the 13 February, she underwent cemented hemiarthoplasty and when the cement was applied her oxygen saturation and blood pressure dropped rapidly and despite attempts at resuscitation she was pronounced deceased at 1pm.

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 emerged during the inquest that during the preoperative assessment inadequate medical history was taken and there was a failure to record her previous myocardial infarction, ischaemic heart disease and pulmonary hypertension. 2. She had severe cardiopulmonary disease and should have been considered as at extremely high risk for major surgery. This should have been discussed with the patient and her family before consent being given. 3. The risks of the procedure may have been reduced by performing an un-cemented operation given the known potential cardiopulmonary complications of cement. 4. The Trust initiated an internal investigation and identified that the root causes were: a) Failure to use existing care bundle and failure to access information across different systems contributed to inadequate pre-operative assessment and failure to highlight patient as high risk. b) Consent process inadequate.
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. 1. Given the finding of the recent audit (Assessment of documentation of risks for hip fracture patients June 2017) to check compliance that documentation of risk discussion has been completed. It is disappointing to note that it was only completed satisfactorily in 8 out of 18 patients. The overall documentation and risk discussion remains poor during both preoperative and post-operative phases. You may wish to consider setting up an urgent review of the issues identified and consider appropriate action to improve compliance.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 August 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; Family. 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	**15 June 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**