	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Heart of England NHS Foundation Trust** **2. St Giles care home**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
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 22/08/2017 I commenced an investigation into the death of Francis Robert Beech. The investigation concluded at the end of an inquest on 12th December 2017. The conclusion of the inquest was Died from bronchopneumonia contributed to by a severely infected fracture site which was not identified and treated in a timely way before he was admitted to hospital on 06/07/17. Signs of infection were present from 01/07/17 and care home and hospital staff did not investigate these in a timely way. Weekly x-rays were not arranged following his discharge from hospital. His death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from chronic obstructive airways disease, hypertension and ischaemic heart disease. He fell at his home address on 21/05/17. He was admitted to Birmingham heartlands Hospital where he was diagnosed with a fracture of the right distal tibia and fibular. Due to his underlying medical problems he was not suitable for surgery so was treated in a plaster cast. Weekly x-rays and an outpatient appointment 3 weeks after discharge were not arranged as required. He was discharged to St Giles nursing home on 16/06/17 for care and rehabilitation. No care plan was put in place to monitor the plaster of paris. He was immobile due to the fracture and existing knee and hip flexion so was bed bound and hoisted from bed to chair. The physiotherapist was concerned about a possible problem with his hip so arranged for an X ray to be undertaken. He was taken to Birmingham Heartlands hospital emergency department on 01/07/17. The paramedic who attended noted pus from his cast and reported this to staff at the hospital who did not record it on the notes. As a result the leg was not further examined and the deceased was returned to the nursing home. On 05/07/17 staff noted a foul smell from the cast and contacted the community nurse and GP. Advice was for the deceased to be readmitted to hospital. There was a delay in the ambulance attending. He was admitted on 06/07/17 where the fracture was noted to now be compound and there was a serious ulcer in relation to the fracture site with pressure sores on the right lateral malleolus and right heel. He was treated with an air cast boot. He was not fit enough for any surgery and sadly died on 09/08/17.. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: BRONCHO-PNEUMONIA CHRONIC OBSTRUCTIVE PULMONARY DISEASE COMPOUND FRACTURE RIGHT ANKLE(INFECTED AND NON UNITED)CHRONIC ISCHAEMIC HEART DISEASE. OSTEOPOROSIS
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. – Heart of England NHS Foundation Trust: 1. Lack of clear guidelines regarding the management of high risk fractures treated conservatively. I heard evidence that this was a high risk fracture as there were sharp edges and little skin over the ankle area. The deceased required regular monitoring as a result. 2. Lack of continuity of care. Each week a different consultant took over his care. This led to a lack of continuity and inadequate discharge planning. 3. Failing to arrange weekly x-rays after discharge to check for fracture alignment and to monitor the fracture. 4. Failing to arrange an outpatient appointment within 3 weeks of discharge. 5. Failing to provide any information to the nursing home about the need to monitor the plaster cast and that it was high risk. 6. Failing to document pus on the cast when he attended for a hip x-ray on 01/07/17. 7. Failing to undertake an internal investigation to ensure lessons were learnt from this case. St Giles nursing Home: 1. Failing to have any care plan for the management and monitoring of his plaster cast. 2. Failing to adequately check the plaster cast for signs of infection 3. Failing to document any signs of infection 4. There has been no further training for staff on plaster casts. The nursing home should review the training needs for staff on the care and management of plaster casts.
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 Wednesday 7th February 2018. 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: the family. I have also sent it to CQC and NHS England who may find it useful or of interest. 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	12/12/2017 Signature_____ Louise Hunt Senior Coroner **Birmingham and Solihull**