IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Michael Christopher Hopkins
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Bradford Teaching Hospitals NHS Foundation Trust**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 14/6/17 I opened an inquest into the death of **Michael Christopher Hopkins** who, at the date of his death was aged 55 years old. The inquest was resumed and concluded on 24/9/18 I found that the cause of death to be: - 1a. Pulmonary Thromboembolism 1b Fracture of Right Patella (operated 13/5/17) I concluded with a narrative conclusion as follows: On 9/5/17 Michael Christopher Hopkins had an unwitnessed fall in the garden of his home address. When taken to Bradford Royal Infirmary, an x-ray indicated that he had sustained a multi-fragmentary fracture of his right patella, which required surgery to correct on 13/5/17, which went without event, and he was discharged on 16/5/17. Subsequently, on 9/6/17, he collapsed at his home address with difficulties breathing, but notwithstanding the attempts of paramedics to resuscitate him, he died from a pulmonary thromboembolism, a known complication of his surgery of 13/5/17.

4	**CIRCUMSTANCES OF THE DEATH** At approximately 4.15pm on 9/6/17 Mr Hopkins had an unwitnessed fall in the garden of his home address. When taken to Bradford Royal Infirmary he was found to have sustained a multi fragmentary fracture of his right patella. Surgery to correct it was carried out on 13/5/17 to correct it, which went without event and he was discharged on 16/5/17. Thereafter post operatively Mr Hopkins struggled with his mobility and complained of pain in his lower ankle and upper thigh. Given the severity of the pain Mr Hopkins visited his GP on 8/5/17 since he thought it was an infection of his wound. After examination the GP confirmed that his wound was not infected and it was dressed. The next day of 9/6/17 he suffered his collapse and died at his home address.
5	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is as follows. – • To review current practice guidelines with respect to the information provided to patients on discharge from hospital that may be at risk of the formation of thromboembolisms given they have had recent surgery after sustaining a trauma.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Bradford Teaching Hospitals NHS Foundation Trust are in a position to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8	**COPIES** I have sent a copy of this report to: • [redacted] – wife of Mr Hopkins • [redacted] – Orthopaedic Surgeon • [redacted] – Inquest Manager • Chief Coroner
9	**DATED this 1/10/18** M D Fleming **M. D. Fleming – Senior Coroner** **(West Yorkshire – Western)**