ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Leeds Teaching Hospitals NHS Trust**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (E).
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 30th January 2020 I commenced an investigation into the death of Mrs Ruby Baggaley, aged 90. The investigation concluded at the end of the Inquest on Monday 15th February 2021. The Inquest resulted in a Narrative Conclusion which records aspects of her care in the hours after surgery was completed. The cause of death was: 1a Myocardial Infarction b Hypotension c Right Distal Femoral Facture (osteoporotic) II Angina, Atrial Fibrillation, Hypertension, Previous Stroke and Frailty
4	**CIRCUMSTANCES OF THE DEATH** Mrs Baggaley aged 90 sustained a facture to her right distal femur on 17 January 2020 in a fall at home. On 24 January 2020 she underwent complex surgery at a specialist centre involving a prosthetic replacement of her knee and a portion of her femur. She was stable following the surgery with an acceptable blood pressure. When taken back to the ward and assessed at 16:54 hours her blood pressure was abnormally low and remained so. This issue was not escalated to a senior colleague until approximately 21:30 hours, by which time she was in a critical condition. She died at 22:25 hours that night in the hospital.
5	**CORONER'S CONCERNS** My concerns relate primarily to the care and treatment provided for Mrs Baggaley in the hours after her complex surgery had been completed. The concerns which were raised at the Inquest are:- 1) On completion of the surgery Mrs Baggaley was deemed to be in a stable condition with a blood pressure of 105/49 and a NEWS Score of 3. She was transferred back to the ward at approximately 16:00 hours. In the following five hours she was located in a bed remote from the nurses' station and was not checked frequently (as might validly be expected in the case of a frail 90 year old lady who has just undergone major surgery). 2) In the four times her blood pressure was checked between 16:00 hours and approximately 20:45 hours it was abnormally low. Her urine output was poor.

In the period from 17:00 hours onwards her care was exclusively in the hands of a relatively junior doctor (CT2) and the nursing staff. No attempt was made to inform the surgeons or anaesthetist of the deterioration in her condition.

3) Between 16:00 hours and 20:45 hours Mrs Baggaley's NEWS Score was 5 and remained at this level. No attempt was made to escalate her care to more senior clinicians.

   It is not clear whether junior doctors and nursing staff now have clear instructions on when to escalate care in such circumstances, nor to whom.

4) By the time the surgeon was informed of the situation and travelled into the hospital around 22:00 hours Mrs Baggaley's condition had become critical.

   It is not clear whether earlier intervention by senior clinicians would have avoided Mrs Baggaley suffering a cardiac arrest consequent upon her low blood pressure (as the Inquest was informed was the case). It is the case, however, that she was deprived of the opportunity to have a review by a senior clinician.

5) I am concerned that in the absence of precise information as to what, if any changes in escalation procedures have been implemented, or additional training provided to the staff involved, the potential for a comparable situation to occur again, remains.

6) Although it is accepted the following factors did not contribute to Mrs Baggaley's death, they served to undermine the trust and confidence of her family in relation to the quality of care provided (particularly when contrasted with that at Leeds General Infirmary).

   - A delay in providing pain relief when she arrived at Chapel Allerton Hospital on the evening of 20 January 2020.

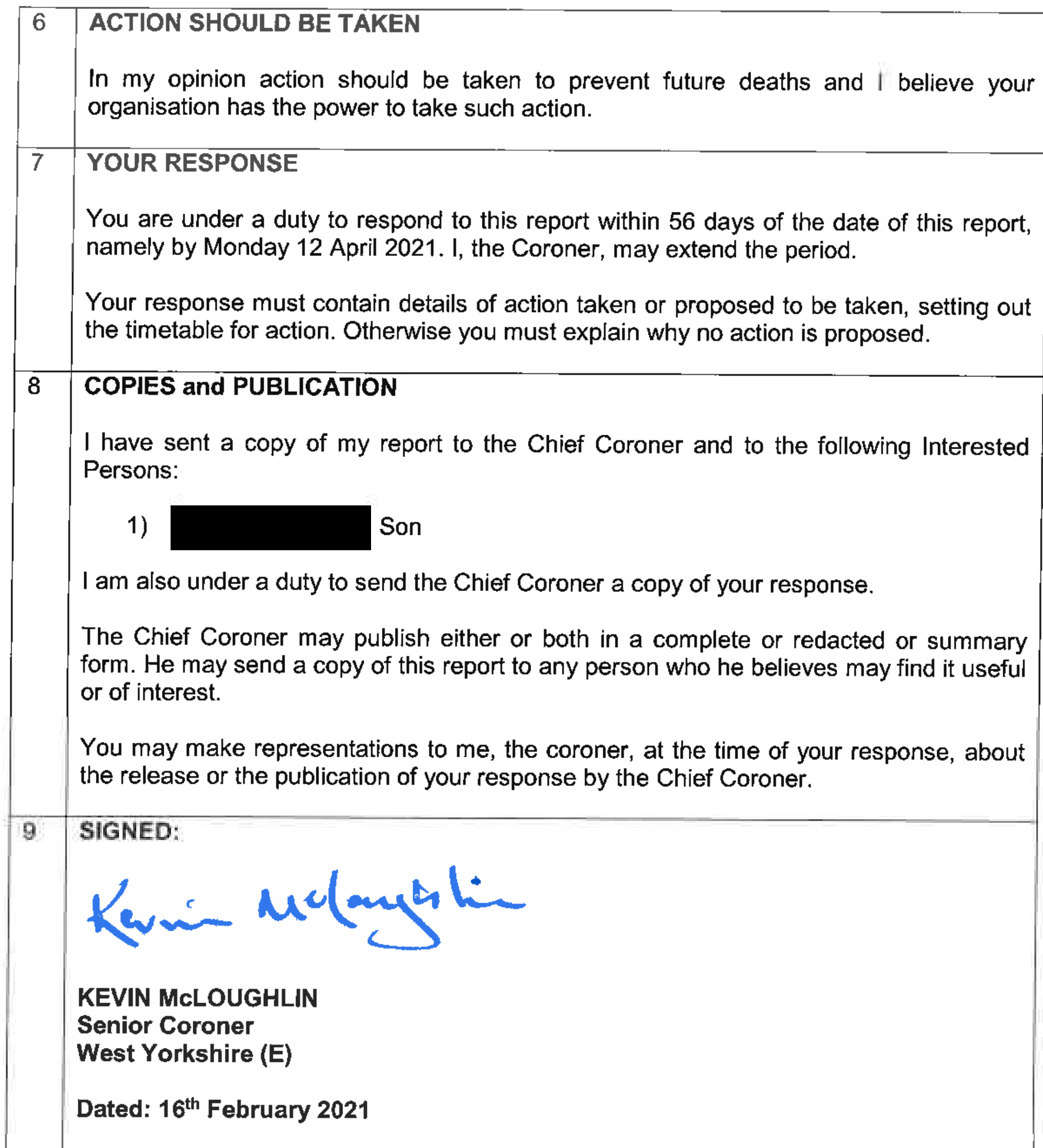
   - The delay in providing a Nimbus Mattress.

   - The delay in arranging traction at Chapel Allerton Hospital, despite this having been written in her Care Plan and being in place when she was in Leeds General Infirmary. The evidence given by a family member was that she was told no-one with the requisite skill was available at the hospital.

   - The cancellation of the surgery arranged for 23 January 2020 on the day it was to take place. This was lamentable not only for a frail 90 year old patient who was in pain, but was also a calamity for the efficient use of NHS resources: a theatre unused for a day; two surgeons each with a day wasted; an anaesthetist's time wasted and one less patient treated overall.

It was certainly acknowledged at the Inquest that Mrs Baggaley's right sided distal femoral replacement surgery was appropriately classified as a high risk procedure. Her care was discussed in two surgical forums before she gave written consent to proceed. The Court applauded the willingness to embark on such surgery. There is little point, however, in investing in surgery of this nature if the post-operative care is not of a comparable standard.

The Trust's response to the family's complaint proclaimed that Chapel Allerton Hospital was the "optimum environment" for Mrs Baggaley's treatment "as the ward nursing staff are also skilled in caring for patients who have undergone this type of surgical procedure" (letter 7 August 2020, Page 2). The evidence taken at the Inquest does not support these contentions. It is for this reason that this Regulation 28 Report is submitted to assist your review of post-surgical care.



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 Monday 12 April 2021. 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] Son 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	**SIGNED:** **KEVIN McLOUGHLIN** **Senior Coroner** **West Yorkshire (E)** **Dated: 16th February 2021**