	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Client Account Manager NSL Care Services 7 Edgemead Road Round Spinney Northampton, NN3 8RJ
1	**CORONER** I am Anne Mary Christine Pember, Senior Coroner for the coroner area of Northampton.
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 29th Jan 2014 I commenced an investigation into the death of X Rokeby aged 46 years. The investigation concluded at the end of the inquest on 21st Jan 2015. The conclusion of the inquest was:- Mr Rokeby died of a complication following the formation of a fistula to enable dialysis. X Rokeby received dialysis on a regular basis and had had a fistula inserted in his left arm. On 18th December 2013 Mr Rokeby complained of pain and swelling over the fistula. It was considered he may have "bumped" the fistula and dialysis proceeded without incident. On 19th December 2013 the patient again contacted the dialysis unit complaining that his fistula remained swollen and painful. He was advised to attend NGH specialist renal ward for assessment if he was concerned. On 20th December 2013 the patient attended for routine dialysis. His fistula remained swollen and painful and he was advised to attend the specialist renal ward at NGH for further assessment. He did attend, a possible diagnosis of cellulitis was made and the patient (Mr Rokeby) was discharged with antibiotics. On 21st December Mr Rokeby again reported a painful fistula. He was advised to attend at NGH specialist renal ward which he did not do. On 22nd December 2013 the patient was collected by a volunteer driver to transport him to his routine dialysis. En route to the hospital Mr Rokeby began to bleed. The volunteer driver pulled into a nearby petrol station. The volunteer driver was advised to apply pressure to the bleeding point and called a 999 ambulance from the roadside. The ambulance attended and conveyed Mr Rokeby to NGH where his death was confirmed at 08.25 hours on the same day. At post mortem the cause of death was:- 1 a) Haemorrhage from dialysis fistula
4	**CIRCUMSTANCES OF THE DEATH** Please see above.

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 could 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) At the resumed inquest gave evidence that an action plan had been developed following this sad incident dated April 2014. The agreed action was as follows:-

   Advice is provided to transport services regarding actions to take if spontaneous haemorrhage occurs.
   Evidence of Completion
   Advice/training has been offered to the transport services (email evidence on 28.04.14) also in conversations previously and in stakeholder meeting with commissioners on 12.06.14 and NSL have said they would like this but do not have any time available at present and have provided drivers with first aid training themselves. (email 28.04.14)

   The volunteer driver who attempted to assist Mr Rokeby (
   gave evidence that he had received no such training in this regard whatsoever.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you and 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, namely by 9th April 2015. 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:-.
– father of X Rokeby
- Claims and Inquests Officer at Leicester General Hospital
- Claims and Litigation Officer, Northampton General Hospital

Similarly, you are 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.

9 **[DATE]** **[SIGNED BY CORONER]**
12th February 2015