	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Central Manchester University Hospitals Trust** 2. **Davyhulme Medical Centre**
1	**CORONER** I am Joanne Kearsley Area Coroner, for the Coroner Area of Manchester South.
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 12th May 2014 I commenced an investigation into the death of Bryan Herbert Whitby date of birth the 10th July 1926. The investigation concluded at the end of the Inquest on the 28th October 2014. The conclusion of the inquest was that the deceased had a history of chronic renal failure.
4	CIRCUMSTANCES OF THE DEATH For several months he had been unwell and arrangements were made for him to have a CT scan. The day before the scan his blood results showed a reduction in his renal function. These blood results were not seen by the Radiologist who carried out the scan. The deceased was also on metformin medication at this time. Following the scan on the 6th May further blood tests were ordered (it is not clear who asked for these) and in the meantime the deceased spoke to his GP who sought advice from the hospital. There is conflicting evidence as to the advice given. The blood tests showed a significant deterioration in his renal function following the CT scan. At this point the deceased should have been admitted for urgent treatment. On the 7th May the deceased's GP received the results from the 6th May and arranged admission to hospital. This was not flagged as an urgent admission by the GP. When the deceased arrived at hospital at approximately 3.20pm there was a failure by the admitting medical staff to recognise and treat his urgent medical condition. A treatment plan put in place by a Consultant at 5.45pm was

not carried out. At 9.30pm the deceased's condition deteriorated. There was a delay in transferring him to the High Dependency Unit, during which time his level of consciousness dropped. He died a short time after admission to HDU. There were several missed opportunities in the care of the deceased and on the balance of probabilities this contributed to his death.

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. The deceased had been unwell for some time and had a history of Chronic Kidney Disease Stage 3. He had been referred for a CT scan but the GP Practice were not aware of the date of the scan or that this would take place on the 3rd May.
2. Blood tests taken on the 2nd May were not escalated by the GP or the pathology laboratory and the scan on the 3rd May went ahead whilst he was still receiving metformin medication. The radiologist carrying out the scan did not have access to his blood results from the 2nd May and simply went off the results from the GP referral some time ago.
3. There is no record of who requested further blood tests on the 6th May.
4. The results of the blood tests on the 6th May should have resulted in urgent discussion with the deceased's GP or the deceased himself. There was no escalation of these results by the biochemistry laboratory.
5. Despite the blood results, the deceased was not admitted to hospital as an emergency and there was a delay in recognising the seriousness of these results. I did hear evidence that training for junior members of staff on acute kidney injury has now been delivered.
6. When he was admitted into hospital there was a failure by the treating medical staff to recognise his serious medical condition and then a failure to carry out the required medical treatment.
7. The Inquest also heard evidence that Mr Whitby required transfer to the High Dependency Unit but this could not take place

	immediately as two critical care nurses were required and one had been sent to Manchester Royal Infirmary as was the practice if there were no patients in the HDU at the start of their shift.
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 by 20 May 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 Person, namely [redacted] – son of the deceased. 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	**25 March 2015** **Joanne Kearsley** **HM Area Coroner**