REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) The Partners, Mildmay Medical Practice, 2a Green Lanes, London, N16 9NF**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
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** The investigation into the death of Rita Paton, aged 78, was commenced on 11 December 2014 and concluded at the end of the inquest on 24 April 2015. The conclusion of the inquest was that Mrs Paton died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Paton had a background medical history of type 2 diabetes mellitus, hypertension and chronic kidney disease (CKD). She was also, more latterly, diagnosed with dementia. Mrs Paton died on 8 December 2014 from ischaemic and hypertensive heart disease, which were contributed to by CKD and diabetes mellitus. Concerns had been raised by Mrs Paton's family regarding the diagnosis and monitoring of CKD by her general practitioners, which was a focus of the inquest. I heard evidence that her CKD was appropriately monitored, as part of routine diabetes screening, on an annual basis. However, on the most recent occasion blood tests had been requested to monitor renal function but the testing did not occur. This was not followed-up by the practice. There was no evidence that this caused or contributed to Mrs Paton's death, however. Mrs Paton's chronic kidney disease had prompted referral to a nephrologist some years before her death; but she did not attend this appointment. The reasons for this non-attendance were not clear and there was dispute as to whether further discussions had occurred regarding this, between the GP and family. This raised an issue as to whether the family of a patient with memory problems and possible dementia should be copied into correspondence, taking into account issues of consent and capacity. Mrs Paton experienced vomiting and abdominal pain on the day before her death. She was attended to by several ambulance crews, including a GP who was part of the 'Paradoc' service, provided by London Ambulance Service NHS Trust. On examination

	Mrs Paton had a slow heart rate; this was put down to the fact she was on a beta blocker medication. I heard evidence from her GP that this medication had been used for some time and had never caused a slow heart rate. The family raised concerns that, in circumstances where patients have complex medical problems but may not have full recall of such issues, medical information should be available to ambulance crews and visiting out-of-hours GPs.
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) I am concerned that there is no system in place to ensure that requested blood tests are actually taken and reported back to the GP practice. Although there was no evidence that this issue caused or contributed to Mrs Paton's death, I am concerned that there is a risk of deaths occurring in similar circumstances, unless this issue is appropriately addressed. (2) Mrs Paton's family had concerns, which I share, that where a patient does not have capacity to make decisions about attending medical appointments they might be inadvertently missed when family members are not copied into correspondence. It was accepted that patient confidentiality would normally preclude such direct family involvement but that there may be circumstances when it is in a patient's best interests to use this approach, to ensure that follow-up occurs. It was not clear from the evidence heard at the inquest what steps are taken when a patient is deemed not to have capacity to make this type of health decision. Concerns were raised that there is no 'back-up' process in place and that future deaths could occur as a consequence. (3) The lack of information available to the attending medical crews on 7 December 2014 was also a concern of Mrs Paton's family, which I share. I heard evidence from an attending Paramedic that there is rarely such information available but that it can be of vital importance when undertaking assessments. There was no evidence that, had information regarding Mrs Paton's past medical and medication history been available, the outcome would have been different. However, I am concerned that such circumstances will exist and that the risk of non-availability of this information should be addressed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the addressees, 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 23 June 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 Paton family. 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	**28 April 2015** **Assistant Coroner R Brittain**