REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Medway NHS Foundation Trust**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent & Medway
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 October 2014 I commenced an investigation into the death of Robert Watt, aged 75. The investigation concluded at the end of the inquest on 17th April 2015. The conclusion of the inquest was that Robert Watt died of 1a. Carcinomatosis 1b. Carcinoma bladder 2. Carcinoma Prostate at Wisdom Hospice on 25th October 2014 from a bladder cancer which at the time of diagnosis was too advanced to treat. The conclusion was that he died of natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Robert Watt had a PMH which included chronic kidney disease and prostate cancer. He was under the care of the renal unit at Kent and Canterbury Hospital and the urology unit at Medway Maritime Hospital. In November 2013 he was discharged back to primary care as his prostate cancer was stable. In May 2014 Mr. Watt was referred by his GP through the rapid access protocol to a haematuria clinic run by Medway NHS Foundation Trust. He was to undergo a cystoscopy which did not go ahead. A letter from the clinic to his GP indicates that the reason for this was that Mr. Watt had been in contact requesting to be removed from the waiting list. His wife has no recollection of this having happened nor did they receive a copy of the letter. An investigation revealed that these matters being dealt with by admin staff, the importance of attending the clinic would not have been discussed with Mr. Watt. Although the fact of non-attendance was recorded electronically, a copy of the letter was not placed with Mr. Watt's medical notes, thus when he subsequently attended a urology review, the registrar was not aware of the non-attendance. Had he been aware, the haematuria would have been investigated and on the balance of probabilities he would not have died when he did. On 14th September 2014 Mr. Watt was admitted to Medway Maritime Hospital with weight loss and rectal bleeding. He remained an inpatient for 8 days. During that time although a malignancy was suspected the limited investigations that took place did not reveal the cause of his symptoms. A CT with contrast was not carried out as a renal specialist had advised against it given poor kidney function, but a CT without contrast was not undertaken which the consultant accepted should have been. A urologist was consulted because of haematuria but this was left to a FY1 doctor. An on-call urologist was not asked to review Mr. Watt who was discharged on 22nd September 2014 without a diagnosis for further investigations to be carried out as an outpatient. It was accepted by the consultant urologist that matters should not have progressed in this way. The fact that Mr. Watt had a high grade advanced bladder cancer was diagnosed by CT following an admission on 26th September 2014 to Kent and Canterbury Hospital when Mr. Watt's wife sought an alternative opinion. Although Mr. Watt underwent a TURB the cancer was incurable and he died on 25th October 2014

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. – i. No party explained the importance of attendance at the haematuria clinic to Mr. Watt or his wife ii. The letter communicating the cancellation of the clinic was not sent to the deceased, nor was it placed on the medical records iii. There is no documentation relating to the referral to urology and forward management of the haematuria within the medical records iv. On each occasion that the medical team consulted with renal or urological physicians in seeking advice how to manage their patient, the consultation was conducted through the most junior doctor on the ward (FY1) v. A urologist was not asked to review Mr. Watt in circumstances where a malignancy was suspected and he was suffering from weight loss and haematuria both of which are recognised symptoms associated with bladder cancer vi. The evidence has shown (although it does not relate to the death) that Mr. Watt was discharged from the hospital even though he was scheduled to have an OGD at the hospital on the date of discharge, which it appears that the physicians were unaware of.
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 22nd 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 following Interested Persons – [redacted] (wife). I have also sent it to [redacted] who may find it useful or of interest. 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	**17th April 2015** [redacted] **Patricia Harding** **Senior Coroner Mid Kent & Medway**