REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive of the Royal Cornwall Hospital, Treliske, Truro**
1	**CORONER** I am Dr E Emma Carlyon for the Coroner area of Cornwall and the Isles of Scilly
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** **Margaret Erskin Hare Wakefield died on 5 February 2016 at the Royal Cornwall Hospital, Treliske, Truro and an inquest was opened on 11 February 2016. The inquest hearing took place on 3 October 2016. The inquest found an Open Conclusion with the cause of death recorded as 1a ischaemic heart disease 1b Severe Coronary Artery Atherosclerosis with stenting 4 February 2016 II Chronic Kidney disease.**
4	**CIRCUMSTANCES OF THE DEATH** Margaret Wakefield was admitted to the Royal Cornwall Hospital, Treliske, Truro on 16 January 2016 with chest pain and end stage renal failure (3x time a week dialysis). She was diagnosed with severe ischaemic heart disease with coronary artery stenosis together with diabetes, high blood pressure, peripheral vascular disease and unstable mental health (Bipolar Disorder). On 4 February 2016 she underwent rotational atherectomy and Percutaneous Coronary Intervention and an intra-aortic balloon pump was used to maintain her blood pressure. The procedure was challenging due to the extent of the stenosis but despite the drill becoming stuck, this was rectified and she was stabilised and transferred back to the ward. She was due to have her dialysis on the morning of 5 February, but she became unwell and unsuitable for haemodialysis. She instead required haemofiltration on the Critical Care Unit however there were no beds/staff available until 23:00 hours. Prior to a bed becoming available she developed chest pain and had a cardiac arrest. Despite resuscitation attempts she died that day as a consequence of her severe heart and renal disease. It was not clear whether to what extent the procedure or lack of availability of haemofiltration hastened her 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. – Margaret Wakefield suffered from unstable mental health which on occasions meant she

	had lack of insight into her medical needs. It was recognised by both the Cardiac Surgeon and Renal Consultant that she was very unwell, the procedure was high risk and that she would require dialysis and that Critical Care haemofiltration may be required. Mrs Wakefield deteriorated quickly and when a request for haemofiltration (which was necessary and potentially lifesaving) was made it was not available in a timely way. The lack of haemofiltration resulted in further deterioration and death occurred before the facility could be made available. The Consultant Surgeon and Renal Consultant both raised concerns as to the lack of haemofiltration for a patient with chronic renal disease following high risk heart procedure in a timely way, and the need for improved access to timely haemofiltration and contingency planning between the treating clinicians and Specialist critical care team.
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. To review the clinical pathway of patients requiring regular haemodialysis when undertaking cardiac procedures and other surgery to ensure a smooth treatment pathway is in place prior to procedure to deal with renal complications should they arise.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 January 2017 (this allows for the festive period). 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] 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	**[DATE]** **14 November 2016** **[SIGNED BY CORONER]** Elizabeth Emma Carlyon