REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an Inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Clinical Director, The Royal Albert Edward Infirmary, Wigan Lane, Wigan WN1 2NN **2.** The Clinical Director, Salford Royal Hospital, Stott Lane, Salford M6 6HD
1	**CORONER** I am Timothy W Brennand, HM Assistant Coroner for the Coroner Area of Manchester West.
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 24th November 2016 I commenced an investigation into the death of Katherine Anne Derbyshire, aged 74. The investigation concluded at the end of the Inquest on the 19th May 2017. The medical cause of death was determined to be:- Ia Chronic Renal Failure II Coronary Artery Atheroma; There was a narrative conclusion that Katherine Anne Derbyshire died as a consequence of recognised complications of renal dialysis combined with the effects of naturally occurring disease.
4	**CIRCUMSTANCES OF THE DEATH** The deceased, who had a history of end stage chronic kidney disease, left renal artery stenosis, myocardial infarction, severe osteoarthritis, hypertension and peripheral vascular disease commenced elective dialysis in January 2016 at her residence at the Carrington Court Care Home, 190 Derby Lane, Hindley, Wigan. In November 2016, carers noted compromised dialysis function and on the 12th November 2016 she was admitted to the Royal Albert Edward Infirmary, Wigan and diagnosed with presumed blockage and infection to a peritoneal catheter that had been inserted in December 2015. The deceased was correctly assessed as requiring an early transfer that did not become available until the 20th November 2016 by which time the deceased's condition was to rapidly deteriorate to the extent she was unfit for transfer.

	Palliative end of life medications were then prescribed until her expected death on the 21st November 2016. Post mortem examination revealed one end of the catheter to have curled and thereby impaired function.
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: The deceased was last dialysed at her care home residence on the 4th November 2016 before being admitted as an in-patient at the Royal Albert Edward Infirmary on the 12th November 2016 and correctly assessed as requiring transfer for ongoing dialysis treatment at the Salford Royal Infirmary. However:- a. No transfer to Salford Royal Infirmary, in fact, took place; b. By the time a bed had become available on the 20th November 2016, the condition of the deceased had deteriorated to the extent that transfer could not take place and she was too unwell to tolerate alternative short term dialysis treatment that could be offered at the Royal Albert Edward Infirmary; c. Whilst there was evidence of an active plan of management in the treatment and care of the patient as between the two hospitals, that plan did not provide for action to be taken in the event of the deterioration of the patient as observed in the circumstances of this case; 2. At the Royal Albert Edward Infirmary it would have been possible to consider hemofiltration as a temporary measure, the evidence suggested that: a. This possible alternative was not considered earlier; b. The reason for the deferment of an alternative temporary dialysis at Royal Albert Edward Infirmary was the expectation of a bed becoming available at Salford Royal Infirmary, but there was no evidence that the clinical needs of the patient had been triaged in a manner that effected transfer at an appropriate stage of her treatment and care; c. The quality of communication between the 14th-20th November 2016 raises a fundamental issue of concern in the appropriateness of her treatment and care in light of the fact that the patient was last dialysed on the 4th November 2016. d. There was no evidence received at the Inquest as to when the Royal Albert Edward Infirmary was informed by the Salford Royal Infirmary that a bed was or would have been available for the patient; 3. Accordingly, the case raises issues as to the nature and extent of communication between the two hospitals and the management of patients admitted at Royal Albert Edward Infirmary requiring ongoing dialysis

	treatment and care.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 11th August 2017. 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:- 1. [redacted], Next of Kin 2. [redacted], Consultant Renal Physician, Salford Royal Infirmary. 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	**Dated** **16th June, 2017**	**Signed** **Timothy W Brennand, Assistant Coroner**