REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Dr John Patterson, Chief Clinical Officer - Oldham Care Commissioning Group 2. Sir David Dalton, Chief Executive – Northern Care Alliance NHS Group 3. [redacted] St Chad's Medical Practice, Lime Green Parade, Oldham 4. Ms Claire Molloy, Chief Executive - Pennine Care Foundation Trust
1	**CORONER** I am Nicholas Flanagan , Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 12th October 2018 I commenced an investigation into the death of **John Andrew Mellor**
4	**CIRCUMSTANCES OF DEATH** John Andrew Mellor suffered from diabetes mellitus, chronic kidney disease and deep vein thrombosis, which had previously caused cerebrovascular accidents and required warfarin therapy. He was under the care of his GP, as well as specialist teams, particularly the Department of Renal Medicine at Salford Royal Hospital. On the 10th August 2018 he attended the Renal Medicine outpatient clinic, where he was commenced on Erthropoietin (EPO) treatment due to acute anaemia. Salford Royal Hospital sent a letter to Mr Mellor on the 10th August 2018, with a copy sent to his GP, asking him to arrange Full Blood Count tests with his practice nurse or district nurse around the 24th August 2018 and every two weeks thereafter. Mr Mellor made extensive efforts to have his blood tested, however his GP practice stated they did not have capacity to undertake the tests and the District Nursing Team indicated that as he was not house bound, they would not perform the tests. Mr Mellor was eventually able to have his blood taken and tested at the Royal Oldham Hospital on the 24th August. On the 31st August 2018, a further letter was sent by Salford Royal Hospital to Mr Mellor, although this letter was not copied in to his GP. The letter informed him that he was due to have a Full Blood Count, among other tests and that he should take the letter to his GP or come to the clinic in Salford if he had an appointment. The letter told Mr Mellor to mark the samples for them to be returned to the Renal Medicine Department. Mr Mellor was not due to be seen by the clinic for some time. All attempts made by Mr Mellor or his representatives to have his blood tested by his GP, the District Nurses or Royal Oldham Hospital proved unsuccessful, with each agency indicating it was not their responsibility. Mr Mellor was constantly passed between agencies. There were insurmountable difficulties, for practical, financial and health reasons, with Mr Mellor attending Salford Royal Hospital from his home address to have his blood tested fortnightly. Due to the absence of blood tests, Mr Mellor was advised not to administer the EPO. Mr Mellor continued to have his INR levels checked throughout August and September 2018, indicating normal INR levels. On the 27th September, Mr Mellor attended a clinic in Salford, his blood was tested and results the following day revealed a very low blood count requiring an urgent transfusion. Mr Mellor was contacted, but he collapsed at home on the morning of the 28th

	September and was taken to the Royal Oldham Hospital. Despite extensive treatment, his condition deteriorated and he died on the 3rd October 2018. The Inquest established the cause of death as: 1a End Stage Renal Failure 1b Diabetic Neuropathy 2 Upper Gastrointestinal Bleed, Anti-Coagulation Therapy, Deep Vein Thrombosis. The inquest could not establish whether the failure to administer the EPO caused or contributed to Mr Mellor's death. The Inquest heard evidence from the Next of Kin and General Practitioner, which detailed the unsuccessful steps that were taken to obtain a blood sample, as well as contemporaneous notes of the communication between agencies at the time. The GP has since sent a letter to the local Care commissioning Group, Dr Patterson, relating to his concerns regarding deficiencies in the care interface. The Conclusion of the Inquest was: **Natural causes to which the known side effects of necessary anti-coagulation therapy more than minimally or trivially contributed.**
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:- That there appears to have been a systematic failure to ensure that blood tests are conducted, where required, for individuals under specialist, secondary care for renal failure. Individual patients, who may not be local to the specialist centre, will inevitably fail to have the appropriate assessments, care and treatment, in the absence of a clear line of responsibility. The failure to establish a shared care arrangement, or at least to ensure that an organisation was identified in order to undertake blood sampling for drug monitoring, is insecure and unsafe. It is also concerning that responses or updates to referrals, as well as requests for tests in the community, have not been communicated to primary care directly, with the sole reliance on a patient to pass vital documentation on to his primary healthcare provider.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 12th April 2019. 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 namely:- **1.** Dr John Patterson, Chief Clinical Officer - Oldham Care Commissioning Group **2.** Sir David Dalton, Chief Executive – Northern Care Alliance NHS Group **3.** [redacted] St Chad's Medical Practice, Lime Green Parade, Oldham **4.** Ms Claire Molloy, Chief Executive - Pennine Care Foundation Trust **5.** [redacted] acting Next of Kin 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 from. 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: 14th February 2019 Signed: N M Flanagan