INQUEST TOUCHING THE DEATH OF DARREN JONES

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:** Helen Ashley, Chief Executive, Burton Hospitals NHS Foundation Trust
1	**CORONER** I am Mrs Heidi Connor, assistant coroner for the coroner area of Nottinghamshire.
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 3 July 2015, I commenced an investigation into the death of Darren Jones, aged 42. The investigation concluded at the end of the inquest on 19 November 2015. The conclusion of the inquest was natural causes. The cause of death was : 1a Massive left sided pleural and mediastinal haemorrhage. 1b Perforation of the thoracic aorta. 1c Invasive aspergillosis. 2 Chronic kidney disease with renal transplant. I heard from several witnesses at inquest. The Burton witnesses were [redacted] locum consultant physician, and [redacted] locum consultant physician. I read the statement o[redacted] consultant cardiologist, onto the record.
4	**CIRCUMSTANCES OF THE DEATH** <u>Events leading to final admission</u> Darren Jones was born on 15.11.72. His PMH included CKD, ankylosing spondylitis and a type of muscular dystrophy. He had a kidney transplant in 2009. He needed immunosuppressant medication after his transplant. We heard that Mr Jones started to show signs of organ rejection in late 2014. The evidence of Mr Jones' consultant nephrologist [redacted] from Nottingham University Hospitals NHS Trust was that this may have been caused by the prescription of Adalimumab by rheumatologists at Burton earlier that year. She could not say that this was the most likely cause. The organ rejection may have been caused by several other factors. Mr Jones was admitted to hospital in December 2014 and treated for a Cryptosporidium infection. After that admission, he was seen by his GP, and at the [redacted]

	understand [redacted] plan that he would only consult Mr Jones' renal team when re-starting the medication [redacted] evidence was that, if she had been consulted, she would have advised that the medication should not be stopped. I requested a copy of the trust's protocol and that of the Nottingham trust, to look specifically at what guidance there is to doctors at Burton on when to contact patients' renal teams. The protocol provided to me for Burton appears limited in that referral is only mandated where there is AKI stage 3, and no improvement after 24 hours of fluids. The protocol does not deal with transplant patients. 2. <u>Availability of immunosuppressant medication</u> I was advised at the inquest that the medication can now be obtained more quickly than within 24 hours. I was not given more specific information about this, and the experience of Dr Rabbani on 9 March was that the drugs would take 24 hours to arrive. I would be grateful if you would consider the following key points arising out of this inquest : 1. A review of current protocols regarding when renal advice should be sought for patients – particularly those who have undergone transplants. I appreciate that the usual renal team for patients in Burton would be based in Derby. 2. Education and sharing of any new protocols that are created, to all relevant staff. 3. Availability of immunosuppressant drugs at short notice.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 22 January. 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] mother of Darren Jones I have also sent it to Mr Andrew Haigh, senior coroner for Staffordshire, 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	**27 November 2015**