MISS N PERSAUD
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU** **2. [redacted], Chief Executive, Barts Health NHS Trust, Royal London Hospital, Whitechapel Road, London, E1 1BB Email: [redacted]**
1	**CORONER** I am Graeme Irvine, Area Coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** *On the 13th December 2018 I opened an investigation touching upon the death of Evadney Dawkins, aged 77 years old. I opened and inquest on the 7th February 2020. The inquest concluded on the 18th December 2020.The conclusion of the inquest was a narrative conclusion:* *" Mrs Evadney Dawkins was 77, she suffered a fall at home and was taken by ambulance to hospital on 22nd July 2018.* *After assessment, a treatment plan was agreed for Mrs Dawkins with included renal monitoring.*

	Mrs Dawkin's renal function was not monitored until 27th July 2018 when she was found to have sustained an acute kidney injury. Following intensive treatment, the acute kidney injury resolved. Mrs Dawkins sustained a cardiac arrest on 23rd August 2018, she was pronounced deceased later that evening. The cause of death was recorded as; 1.a Multi-Organ failure II Ischaemic and Hypertensive Heart Disease, Chronic Renal Failure, Type 2 Diabetes Mellitus, Pneumonia (resolving).
4	**CIRCUMSTANCES OF THE DEATH** Mrs Evadney Dawkins was 77, she suffered a fall at home and was taken by ambulance to hospital on 22nd July 2018. After assessment, a treatment plan was agreed for Mrs Dawkins with included renal monitoring. Mrs Dawkin's renal function was not monitored until 27th July 2018 when she was found to have sustained an acute kidney injury. Following intensive treatment, the acute kidney injury resolved. Mrs Dawkins sustained a cardiac arrest on 23rd August 2018, she was pronounced deceased later that evening.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. On 22nd July 2018, Mrs Dawkins was assessed to require renal monitoring, incorporating; a) Regular blood tests b) A renal ultrasound c) Fluid intake/output monitoring The 3 actions were not undertaken for 4 days, after which, it was discovered that the patient had deteriorated and had sustained a Grade 3 acute kidney injury. 2. The Trust's governance systems did not assess to a case as a Serious Incident requiring investigation for 2 years.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **15th February 2021**. 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 the family of Mrs Dawkins and the CQC. I have also sent it to the Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**21st December 2020** **SIGNED BY CORONER**