Regulation 28: Prevention of Future Deaths report

Macaulay WILSON (died 26.09.20)

	THIS REPORT IS BEING SENT TO: **1. Dr [redacted] and Dr [redacted]** **Senior Partners** **Lower Clapton Group Practice** **36 Lower Clapton Road** **London E5 0PQ**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 8 October 2020 I commenced an investigation into the death of Macaulay Wilson, aged 87 years. The investigation concluded at the end of the inquest earlier today. I recorded a medical cause of death of: 1a urosepsis 1b long term indwelling catheter not changed since October 2019 2 Alzheimer's dementia, cerebrovascular accident, chronic kidney disease, bladder cancer and prostate cancer I made a determination at inquest that Mr Wilson died because a failure to change his indwelling catheter for almost a year caused urosepsis. The catheter should have been changed every 12 weeks.

4	**CIRCUMSTANCES OF THE DEATH** Mr Wilson had an indwelling urinary catheter fitted to assist in the management of his bladder cancer. The Homerton University Hospital urology department failed to risk assess his catheter change requirement and so did not recognise that this was too complex medically for district nurses in the community and should be dealt with by the department. Then it cancelled an appointment (because of the COVID19 pandemic) made for 27 April 2020 following a GP referral, and failed to make a plan to bring Mr Wilson back. And finally, his general practitioner having referred him a second time on 31 July 2020, the HUH urology department failed to make another appointment. Meanwhile, the Homerton University Hospital district nurses visited Mr Wilson every week for catheter *care*, but never enquired as to whether there had been any catheter *change*.
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. (I should say that I heard at inquest that Homerton University Hospital has formulated an action plan to minimise the risk of recurrence.) The **MATTERS OF CONCERN** are as follows. The Homerton University Hospital urology clinical nurse specialist wrote to your practice on 18 February 2019, and included within the letter a request that you arrange for district nurses to change Mr Wilson's indwelling catheter in 12 weeks. A doctor from your practice did consider the letter, did action it and did write to the district nurses, but did not include a specific request for catheter *change* (as opposed to catheter care, which does not include change of the catheter). It seems that your doctors' use of language in this situation would benefit from further consideration.

6	**ACTION SHOULD BE TAKEN** In my opinion, 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 5 July 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 following. • [redacted], son of Macaulay Wilson • Dr [redacted], medical director, Homerton Hospital • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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	**DATE** **SIGNED BY SENIOR CORONER** 07.05.21 *ME Hassell*