

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO:

1. Chief Executive, The Northern Care Alliance NHS Trust

1 CORONER

I am Julie Robertson, 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 9 April 2021 an investigation into the death of Mohammed Abdus Salem was commenced. The investigation concluded at the end of the inquest on 14 October 2021, I recorded a conclusion of death by natural causes.

4 CIRCUMSTANCES OF DEATH

The deceased was diagnosed with chronic myelomonocytic leukaemia (CML) in October 2020. This illness was managed conservatively and the deceased required and received regular blood transfusions and oral chemotherapy to maintain control of his white cell count.

The deceased's health remained stable until March 2021 when his condition deteriorated significantly. It was noted that the deceased's CML had rapidly progressed. On 29 March 2021, the deceased was admitted to the Royal Oldham Hospital for inpatient treatment. He was treated with intravenous fluids and antibiotics and his oral chemotherapy medication dose was increased.

By 31 March 2021 the deceased's condition had further deteriorated. He was commenced on Rasburicase to reduce the risk of him developing tumour lysis syndrome. While it was intended that the deceased receive a further dose of Rasburicase on 1 April 2021 this drug was not given despite high urate levels being detected. This was medication that could either be administered as a single dose or as part of a longer course. I heard evidence that the prescribing doctor intended that the Deceased receive more than one dose however this was not specified in the notes or in the prescription. The clinicians who reviewed the deceased on 1 April 2021 assumed that only one dose was required.

During the late evening of 1 April 2021, the deceased was discovered unresponsive. His death was confirmed shortly afterwards on 2 April 2021.

It is more likely than not that had a further dose of Rasburicase been administered to the Deceased on 1 April, his life would have been prolonged by up to 48 hours.

5 CORONER'S CONCERNS

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 is as follows:-

1. The Root Cause Analysis (RCA) undertaken by the Northern Care Alliance identified that a dose of Rasburicase had not been administered on 1 April 2021 however it did not consider any of the factors that gave rise to that omission or its consequences. My concern is that the RCA fell short of

	the required standard of rigour which leaves residual questions as to organisational governance standards and learning from death.
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 13 December 2021 I, Julie Robertson, the Assistant 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:-
	Family of Mohammed Abdus Salam The Care Quality Commission
	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.
	Date: 18.10.21 Signed: