Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Medical Director: Aneurin Bevan University Health Board 2. Senior Partner, Richmond Clinic, Newport
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 17/11/20 an investigation was opened into the death of Brian Wareham The investigation concluded at the end of the inquest on 16/12/2021 when I determined the following: The conclusion of the inquest was recorded as: Death from Natural Causes. **The medical cause of death was:** 1a) Multi-organ failure 1b) Oesophageal Dysmotility 2) Small Cell Carcinoma

4	**CIRCUMSTANCES OF THE DEATH** Brian Wareham was diagnosed with oesophageal dysmotility in May2020. His condition gradually worsened, and he was unable to eat sufficiently to maintain his nutritional status. This put Brian's body into a fatal decline, and he died from the effects at St David's Hospice on 2nd November 2020.
5	**CORONER'S CONCERNS** During the course of the inquest, 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: - 1. <u>Communication and collaboration between primary and secondary care.</u> Brian Wareham had been admitted to hospital in May 2020 with ongoing symptoms of weight loss, dysphagia and general weakness. He was discharged in June 2020 with a package of care and the treating clinicians felt that his condition had stabilised. There was no immediate cure for Brian's problems and he was provided with advice about a softer, more manageable diet. In evidence his GP (Dr [redacted] of the Richmond clinic in Newport) stated that he thought Brian should have remained in hospital, that he was not fit to be at home. Dr [redacted] stated that he did not understand the relationship between Brian's gastroenterology problems and his newly diagnosed lung cancer, specifically whether he was for active treatment or whether the approach was to be palliative. Given the GPs considerable concerns which he voiced with frustration and disdain, I questioned why he made no effort to try to address these problems by directly contacting the medical team in Nevill Hall Hospital responsible for Mr Wareham and who had in fact written to the GP practice at the time of his discharge. When these questions were put to Dr [redacted] he stated that he thought this would be futile and it appeared that there was a significant breakdown in communication, trust and respect between primary and secondary care. The current situation appears to leave vulnerable patients without appropriate information and support due to a breakdown in the relationship between clinicians.

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. <u>I should be grateful if the following information be provided to me:</u> 1. Confirm that this matter will be investigated. That the specific obstacles to communication in this case will be addressed and a collaborative action plan to improve the relationship between GPs (either specifically or more generally in Gwent) developed.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 11.03.2022, I, the Coroner, may extend this 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 necessary.
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) • **The family of Brian Wareham** • **Health Inspectorate Wales.** 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 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	**DATE 14.01.22** Signed C Sanders

	Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**