Derek Winter
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt Hon Jeremy Hunt** **Secretary of State for Health** **Department of Health** **Richmond House** **79 Whitehall** **London SW1A 2NS**
1	**CORONER** I am Derek Winter, Senior Coroner for the City of Sunderland
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 12th February 2015 I commenced an investigation into the death of George Richardson, aged 84. The investigation concluded at the end of the Inquest on 12th May 2015. The conclusion of the Inquest was a "Natural occurring heart condition contributed to by complications from catheterisation".
4	**CIRCUMSTANCES OF THE DEATH** George Richardson died in Sunderland Royal Hospital on 9th February 2015 at 05:10 hours having been admitted on 20th January 2015. He went into urinary retention and required catheterisation on several occasions by different individuals during which time he suffered urethral trauma. The cause of death following the Post Mortem Examination was: - Ia Ischaemic Heart Disease; Ib Coronary Artery Atheroma; II Traumatic Urethral Catheterisation and Infective Exacerbation Of Chronic Obstructive Pulmonary Disease.
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. The **MATTERS OF CONCERN** are as follows. – Catheterisation was carried out including attempts/manipulation on several occasions by different individuals without recourse to a consolidated catheterisation record. Individuals were not always aware of previous catheter challenges so as to promote the involvement of a

Civic Centre, Burdon Road, Sunderland, SR2 7DN
Tel 0191 5617843 | Fax 0191 5537803 | DX 60729 Sunderland
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	Urologist. The Trust are addressing their Catheterisation Policy but as there are 33,000 such procedures undertaken there each year, the skills required for safe and effective catheterisation may require national standards to be set.
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 Monday 13th July 2015. 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: - • Family • City Hospitals Sunderland NHS Foundation Trust and their Solicitors • 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 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	Dated this 15th day of May 2015 Signature [redacted] Senior Coroner for the City of Sunderland