North East Kent Coroners
Aberdeen House
68 Ellington Road
Ramsgate
CT11 9ST

Telephone:
New and Current Cases: 03000 410603
General Enquiries: 03000 410604
Email: nekcoroner@kent.gov.uk

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: East Kent Hospitals NHS Foundation Trust**
1	**CORONER** I am Alan Blunsdon Assistant Coroner for **North East Kent**
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 29/02/2016 I commenced an investigation into the death of Andrew Jonathan WILSON. The investigation concluded at the end of the inquest 28th April 2017. The conclusion of the inquest was Andrew Jonathan Wilson died on the 31st July 2015 at the Kent and Canterbury Hospital, Ethelbert Road, Canterbury, Kent. He had been admitted to Maidstone Hospital on 20th July 2015 with a diagnosis of sepsis. An Inquest failed to establish the source of the sepsis. He was transferred to the renal unit at Kent and Canterbury Hospital. He deteriorated and died of natural causes. 1a **Sepsis (unknown origin)** b c II **End-stage Renal failure (on peritoneal dialysis), Diabetes Mellitus, Congestive Cardiac Failure, Dilated Cardiomyopathy**
4	**CIRCUMSTANCES OF THE DEATH** Mr Andrew Wilson had a complex medical history which involved careful cardiac and diabetic management. He developed chronic kidney disease and in February 2015 he presented with worsening cardio-renal failure and underwent temporary haemodialysis via a femoral line on ICU in Maidstone Hospital. Long term treatment was arranged with the Renal Unit at the Kent and Canterbury Hospital but for convenience patients can be seen by the Renal Unit Consultant at a number of satellite sites throughout Kent. Mr Wilson was not suitable for haemofiltration within the Renal Unit and elected from March 2015 to have peritoneal dialysis each night at home. This method of treatment is outsourced by the Renal Unit and supplied and supported by a private organisation. The use of peritoneal dialysis equipment requires specialised training for both the medical care staff and the patient. Mr Wilson was admitted to the Maidstone Hospital on the 20th July 2015 suffering from blurred vision, considerable abdominal pain and reduced ability to pass urine. A diagnosis of sepsis associated with several potential sites was made. Although Mr Wilson had a nightly regime of home peritoneal dialysis in place, neither Maidstone Hospital nor the satellite renal unit could provide such dialysis for the nights of 20th, 21st, 22nd July 2015. The explanation for the absence of dialysis provided by the East Kent Hospital Trust is that there are insufficient numbers of trained clinical staff available to provide peritoneal dialysis treatment at Hospitals outside the Renal Unit at Canterbury. Further the outsourced staff would not be permitted to provide treatment within the hospital. Mr Wilson was transferred to the Renal Unit at the Kent and Canterbury Hospital on the 23rd July 2015 and peritoneal dialysis was recommenced. Mr Wilson was eventually overwhelmed by the sepsis and died.
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. – (1) Although it was established on the balance of probability (after hearing the clinicians and an independent expert Consultant Nephrologist) that the absence of peritoneal dialysis on **THIS** occasion did not contribute to the death, the absence of any arrangements to provide peritoneal dialysis at hospitals other than the renal unit at Canterbury raised a concern. (2) There was an apparent absence of knowledge on the part of the treating clinicians at Maidstone Hospital that peritoneal dialysis could not be arranged either during the day or over –night at that hospital as there were no trained staff available nor was the equipment available. There were no arrangements in place to transport the equipment from the home of a patient to the hospital.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you East Kent Hospitals NHS Foundation Trust 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 3rd July 2017. 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 [redacted], Maidstone and Tunbridge Wells NHS Trust. 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	08/05/2017 Signature:  Alan Blunsdon Assistant Coroner **North East Kent**