REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Lesley Dwyer, Chief Executive, Medway NHS Foundation Trust.
1	**CORONER** I am Allison Summers, Assistant Coroner, for the coroner area of Mid Kent and Medway.
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 21st December 2017 an inquest concerning the death of BERNARD JOHN FAGG was opened. I resumed and concluded the inquest on 17th May 2018. The conclusion of the inquest was that Bernard John Fagg died following a necessary medical procedure.
4	**CIRCUMSTANCES OF THE DEATH** Bernard John Fagg was admitted to hospital on 5/12/17. He had been referred by his GP on that day due to concerns as to breathlessness. Following admission the working diagnosis was of heart failure, anaemia, fast atrial fibrillation and interstitial lung disease possibly asbestos related. There was a history of weight loss. The combination of this with the shortness of breath and anaemia led the clinicians to seek a CT

	scan of the chest. Mr Fagg had a CT scan with contrast (chest) on 7/12/17. His renal function was normal and at that stage there were no indications of any kidney problems. The decision to proceed to a CT scan with contrast was entirely appropriate. Renal function was normal on 8/12/17. An endoscopy had also been requested and this took place on 8/12/17. An endoscopy was entirely necessary in the circumstances of the presentation. The procedure necessarily required the patient be nil by mouth for a number of hours. The patient was stable until 10/12/17 when he developed acute kidney injury. The working diagnosis and indeed cause of death as given by the clinicians was acute kidney injury (non-traumatic) due to contrast induced nephropathy. He was not deemed suitable for dialysis and later died on 14/12/17. Although it is acknowledged that there is an ongoing debate as to whether the contrast presents a risk to kidney function, having regard to the absence of any other factors this was the most likely cause of the kidney injury in this case.
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** is as follows. – Given the proximity of the endoscopy (which required nil by mouth) to the CT with contrast, the concern which arises is whether Mr Fagg should have been considered for and given intravenous fluids. The doctor who gave evidence said that having requested an endoscopy he would not necessarily have known when this procedure would take place. It is not suggested that the endoscopy should not have taken place but during the course of the evidence the doctor did raise the point that had he known that the endoscopy was to take place the day after the CT scan with contrast he may have considered intravenous fluids. The matter of concern is therefore whether a patient, even with normal renal function, should be considered for intravenous fluids in cases where they have had a CT scan with contrast

	and within a short time frame thereafter are required to undergo a procedure which will necessarily mean they will not be allowed to eat or drink for several hours.
6	**ACTION SHOULD BE TAKEN** Consideration as to whether any form of policy or guidance is required to alert clinicians to the fact that when following a CT scan with contrast, a patient is to be nil by mouth for a period of time (for the purposes if other medical procedures) the patient should be considered for intravenous fluids.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 Person [redacted] 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	**[DATE] 17th May 2018** **[SIGNED BY CORONER]** ..... **Allison Summers**