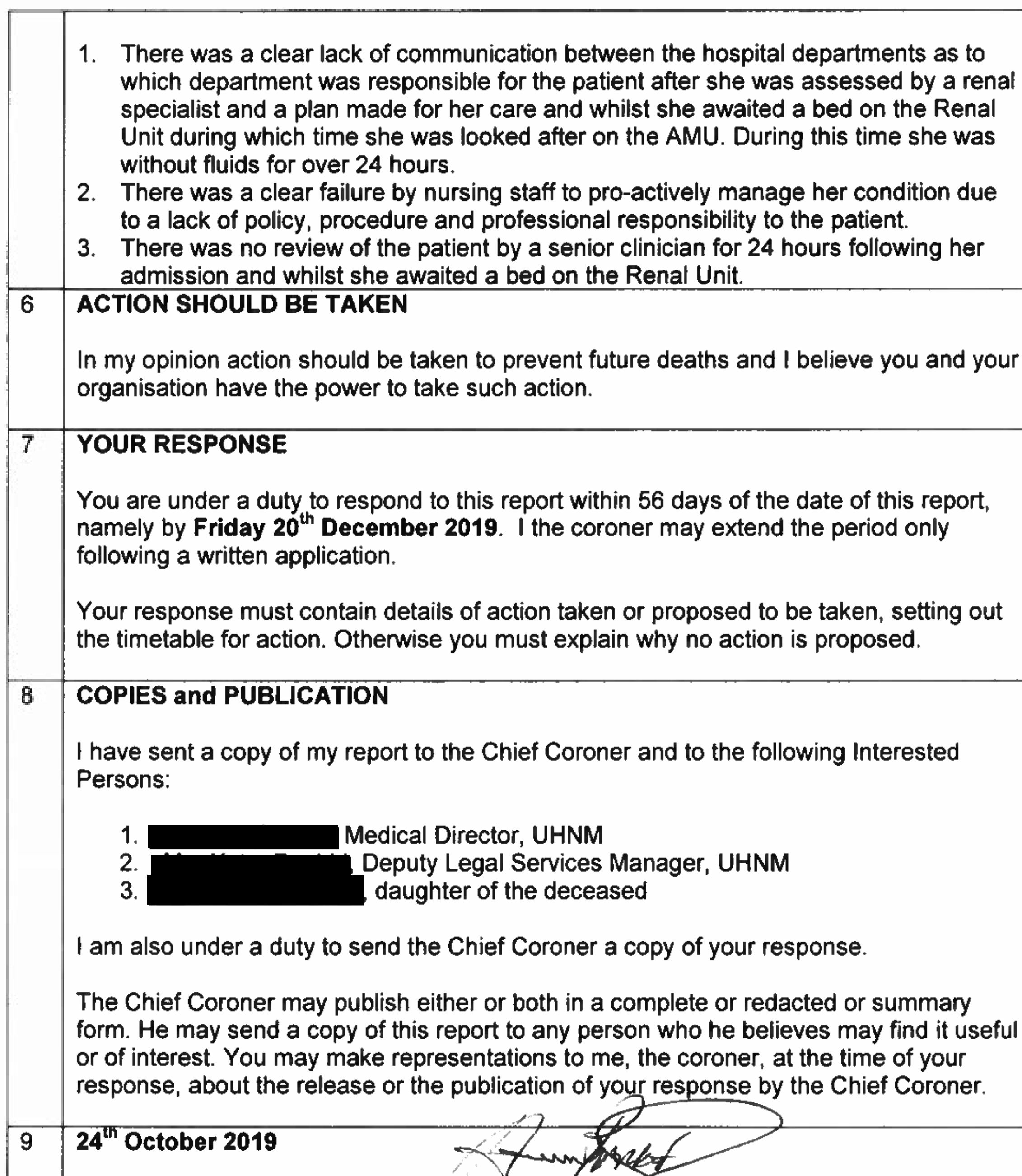
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Ms Tracy Bullock** **Chief Executive, University Hospital of North Midlands** **Trust Headquarters** **City General Site** **Newcastle Road** **Stoke-on-Trent** **ST4 6QG**
1	**CORONER** I am Andrew Barkley, senior coroner for the coroner area of Stoke-on-Trent & North Staffordshire
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 24th January 2019 I commenced an investigation into the death of Julie MORREY aged 58. The investigation concluded at the end of the inquest on 22nd October 2019. The conclusion of the inquest was that Julie MORREY died as a result of 'Natural causes contributed to by neglect' and the medical cause of her death was:- 1a Acute renal failure complicating chronic renal failure post renal transplant for focal segmental glomerulosclerosis/acute tubular necrosis and glomerulonephritis with small thrombosed right kidney. 1b Bronchopneumonia. 1c Chronic obstructive pulmonary disease and multifactorial immunosuppression. II Ischaemic heart disease, lack of fluids.
4	**CIRCUMSTANCES OF THE DEATH** The deceased passed away in the Royal Stoke University Hospital, Stoke-on-Trent on 10th January 2019 having admitted herself there on 7th January 2019. She had a number of pre-existing medical conditions, the most significant of which was a transplanted kidney which she had had since 2016. Believing that she was suffering with a chest infection, she visited her GP on 4th January 2019 but self-presented to Accident and Emergency on 7th January 2019 where she was recognised as suffering from renal failure and bronchopneumonia. Despite timely review by a renal specialist, she was not provided with adequate fluids for over 24 hours by which time her condition had worsened and despite admission to the ICU she deteriorated 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. There was a clear lack of communication between the hospital departments as to which department was responsible for the patient after she was assessed by a renal specialist and a plan made for her care and whilst she awaited a bed on the Renal Unit during which time she was looked after on the AMU. During this time she was without fluids for over 24 hours.
2. There was a clear failure by nursing staff to pro-actively manage her condition due to a lack of policy, procedure and professional responsibility to the patient.
3. There was no review of the patient by a senior clinician for 24 hours following her admission and whilst she awaited a bed on the Renal Unit.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 **Friday 20th December 2019**. I the coroner may extend the period only following a written application.

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:

1. Medical Director, UHNM
2. , Deputy Legal Services Manager, UHNM
3. , daughter of the deceased

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 24th October 2019