

MISS N PERSAUD SENIOR CORONER EAST LONDON

Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref:

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU Chief Executive, Barts Health NHS Trust, Royal London Hospital, Whitechapel Road, London, E1 1BB Email: CORONER 1 I am Graeme Irvine, Area Coroner for the coroner area of East London **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 **INVESTIGATION and INQUEST** 3 On 22nd April 2020 I commenced an investigation into the death of Ivan Merryfield O'Neill aged 74 years. The investigation concluded at the end of the inquest on 20th November 2020. The conclusion of the inquest was a narrative conclusion: " On 21st April 2020 Mr Ivan Merryfield O'Neill attended hospital for dialysis." An accidental dislodgement of a venous needle that takes blood under pressure to the dialysis machine occurred, which led to a significant bleed. Staff on the unit were unaware of the bleed, until an alarm from the dialysis machine

sounded due to a drop in pressure. Mr O'Neill was found to be unresponsive

having sustained a cardiac arrest due to hypovolemic shock, despite resuscitation attempts his life was pronounced extinct at 09.30 hours."

The cause of death was recorded as:

1a; Hypovolemic Shock

1b; End-Stage Kidney Disease

II; Polyneuropathy, Frailty and COVID19

4 CIRCUMSTANCES OF THE DEATH

During a regular dialysis appointment, Mr O'Neill bled to death when a venous needle became dislodged from the site of his arteriovenous fistula.

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 could 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. Mr O'Neill was known to be a restless patient during a dialysis session. This factor must have increased the risk of needle dislodgement.
- 2. Mr O'Neill was a frail patient with little reserve and would be more likely to swiftly lose consciousness following a bleed.
- Mr O'Neill was placed in a position which was outside of a clear line of sight from the nurses station.
- The automatic alarm triggered by the dialysis equipment was insufficiently sensitive to promptly alert staff to a bleed until between 200 – 2000 mls of blood had already been lost.

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 **27**th **January 2021**. 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 the family of Mr O'Neill and the CQC. I have also sent it to the Director of Public Health who may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

9 2nd December 2020

[SIGNED BY CORONER]