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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1) [redacted], Chief Executive, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester WR5 1DD |
| 1 | **CORONER**<br><br>I am David Donald William REID, HM Senior Coroner for Worcestershire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br><br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 18 May 2023 I commenced an investigation and opened an inquest into the death of Paul William BRADLEY. The investigation concluded at the end of the inquest on 18 January 2024<br><br>The conclusion of the inquest was that Mr. Bradley *"died from natural causes."* |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>In answer to the questions "when, where and how did Mr. Bradley come by his death?", I recorded as follows:<br><br>*"In July 2019 Paul Bradley was diagnosed with renal cancer. Over the next two years his renal tumour was monitored, and by February 2021 it was felt that he should now be considered for a nephrectomy. When he failed to attend a urological appointment in March 2021, this was not followed up by the urology team and no further appointment was arranged until he was referred again by his general practitioner in May 2023, after a CT scan had shown a metastatic renal tumour. He was admitted to the Alexandra Hospital, Redditch for palliative treatment and declined and died there on 17.5.23. The failure to try to arrange a further urological appointment after March 2021 represents a missed opportunity to provide Mr. Bradley with treatment which may have prolonged his life.*" |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>In the course of the inquest, I found the following facts to have been established:<br>1) Although Mr. Bradley had already been documented to have been hard of hearing, the urological appointment he was offered in March 2021 was by telephone, and he had not confirmed prior to that appointment that he would be willing and able to attend it. It is quite possible that he did not hear the telephone when attempts were made to contact him. It was conceded at |

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| | inquest by [redacted], who conducted a serious incident investigation on behalf of the Trust, that it was a mistake to have tried to arrange this appointment by telephone, and that it should have been conducted in person;<br>2) After the urology appointment in March 2021 was missed, there is no evidence that letters seeking to rearrange it were sent either to Mr. Bradley or to his GP. In his evidence at the inquest, [redacted] stated: *"[ the Trust's ] tracking system should have picked up on the fact that Mr. Bradley's treatment targets had not been met"*; and "*the urology team's system for tracking cancer patients needs to be improved..."* but that *"[ there is ] still some disagreement as to how this should be done".*<br>3) Between March 2021 and December 2022, despite receiving no follow up from the urology team, Mr. Bradley continued to have appointments with Prof. Downing's vascular team, to whom he had been referred because of a potential weakness in his aorta, which may have affected the decision to proceed with a nephrectomy. He did not, however, attend for PET scan appointments in the summer of 2021 which the vascular team had organised. There is no evidence that the vascular team wrote to Mr. Bradley or to his GP about those missed scan appointments;<br>4) Despite contact with the vascular team relating directly to his urological issues, there is no evidence that either team contacted the other about Mr. Bradley's missed appointments; nor did the vascular team update the urology team about the appointments which Mr. Bradley did attend. In his evidence at the inquest, [redacted] stated: *"I think the vascular team should have been keeping the urology team abreast of their contacts with Mr. Bradley. I think maybe they lost focus of the bigger picture, i.e. that these vascular investigations were being done because of the potential renal surgery."*<br><br>I was therefore satisfied that:<br>(a) The Trust's urology team had no clear system in place to try to ensure that a patient who missed an important urology appointment could be followed up, and his treatment targets met. That still appears to be the case;<br>(b) Where, as here, more than one team was involved in a patient's care, there was no clear system in place to ensure that the teams involved communicated with each other about the progress they were making with the patient, and about any appointments missed by the patient. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of Worcestershire Acute Hospitals Trust, have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **22 March 2024.** I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following: |

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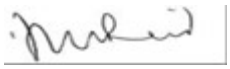
| | (a) [redacted] ( Mr. Bradley's brother ).<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful 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 | **26 January 2024**<br><br>  <br><br>**David REID**<br>**HM Senior Coroner for Worcestershire** |