Regulation 28: Prevention of Future Deaths report

Abu RAHMAN (died 20.11.2024)

	THIS REPORT IS BEING SENT TO: The Medical Director, CEO and Legal Department of: Royal Free Hospital Pond Street London NW3 2QG
1	**CORONER** I am: Harry Lambert Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 21 November 2024 an investigation was commenced into the death of Abu Rahman aged 88 years. The investigation concluded at the end of the inquest held on 25th and 26th March 2025. The Inquest found that Abu Rahman, aged 88, suffered a traumatic fall in which he broke his hip. He underwent hemi-arthoplasty from which he initially recovered well. He later deteriorated, his decline driven by pneumonia on a background of pre-existing end stage renal failure. The medical cause of death was: 1a Pneumonia 1b Fractured Neck of Femur

	1c Traumatic Fall 2 End stage renal failure, and Type II Diabetes Mellitus. I returned a Conclusion of Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Please see attached Findings of Fact.
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. Firstly, I heard evidence from the family that nursing staff were frequently unable to administer Naloxone as it had run out. They had to obtain more Naloxone from the pharmacy, which led to delays for "hours and hours" on multiple occasions. Secondly, I heard evidence concerning a lack of awareness or appreciation concerning the risk of opioid toxicity / accumulation in patients with kidney impairment/failure, even where the "correct" dose may have been given. I am concerned that if there is no proper or properly implemented system for obtaining medication in a timely manner, and limited awareness of the matters canvassed above, then this gives rise to a risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 29 May 2025. 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 following. • The British Renal Society / UK Kidney Association • HHJ Alexia Durran, the Chief Coroner of England & Wales 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	**DATE** **SIGNED BY ASSISTANT CORONER**  31.03.25