REGULATION 28: REPORT TOPREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr John Adler Chief Executive, University Hospitals Leicester NHS Trust**
1	**CORONER** I am Lydia Brown assistant coroner, for the coroner area of Leicester City and South Leicestershire
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 the 18th October 2012 an investigation commenced into the death of Karen Lesley SUTTON date of birth 10 November 1959. The investigation concluded at the end of the inquest on 2nd September 2013. The conclusion of the inquest was Natural Causes. The cause of death was 1a. Sepsis 1b. Streptococcus pneumoniae infection 1c. Common variable immunodeficiency and low grade non-Hodgkin Lymphoma and Splenectomy 2. Hepatic cirrhosis
4	**CIRCUMSTANCES OF THE DEATH** Mrs Sutton had been diagnosed with primary antibody deficiency disorder in September 2001 and from this time was under the care of the Immunology teamand her care was led by [redacted] at Leicester Royal Infirmary. As part of her ongoing treatment she underwent splenectomy during 2005, and thereafter required lifelong anti-biotic therapy most latterly in the form of daily azithromycin. She required admissions during August and September 2012 for symptoms of infection, and was treated by the medical teams at Glenfield Hospital. Her admission medications including Antibiotic prophylactic cover were discontinued, and not restarted on discharge. Mrs Sutton was readmitted on 11th October 2012 as an emergency and was found to be suffering from a severe sepsis, and despite timely interventions, went into cardiac arrest and died that evening.
5	**<u>CORONER'S CONCERNS</u>** 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) Not withstanding her 12 year history of regular Immunology follow-up, the team were not notified of her admission to hospital , on either occasion during August and September 2012, and thus given the opportunity to have input into her care and her discharge. (2) Mrs Sutton was discharged home without prophylactic antibiotic medication (3) Mrs Sutton was left to arrange her next out patient appointment and it was fortuitous that [redacted] was able to see her after the day of discharge, 4th October 2012. (4) [redacted] was unaware of any Trust policy to share admissions between departments. He acknowledged this as a Learning point and although he has personally instigated a practice to encourage patients and /or their relatives to let his department know of any admissions, this is neither robust or in some circumstances practical and cannot be relied upon as a means of communication Trust-wide.
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 30 October 2013. 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 [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 4 September 2013** **Mrs L Brown** **H M Assistant Coroner** **Leicester City and South Leicestershire**