REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS This report is being sent to: 1. The Secretary of State for Health **2.** The President, Royal College of Surgeons, London
1	**CORONER** Christopher P Dorries OBE, HM Senior Coroner for South Yorkshire (West)
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** In June 2015 I commenced an investigation into the death of Mrs Kay Morrison. The investigation concluded following an inquest in December 2017 where the narrative conclusion set out that: *Mrs Morrison underwent necessary surgery on the 11th June 2015 at the Royal Hallamshire Hospital, Sheffield. No proper antibiotic history was obtained and Mrs Morrison developed a severe bacterial infection, and subsequently a severe fungal infection, following the (correctly carried out) procedure. Mrs Morrison died of sepsis on the 21st June 2015.* *On the balance of probabilities, the death occurring when it did was contributed to by the lack of a proper antibiotic history.*
4	**CIRCUMSTANCES OF THE DEATH** Mrs Morrison lived in Cumbria but had been referred to the tertiary centre in Sheffield for specialist surgical care. Unfortunately, her historical records not being local, a full and proper antibiotic history was not obtained. It was clear that Mrs Morrison had been subject of many infections and been repeatedly prescribed antibiotics. It could have been recognised that she had previously had an ESBL infection that was not susceptible to certain antibiotics. An independent microbiologist gave evidence that there was a history of UTI's treated with antibiotics both at various hospitals and in the community. There were two positive tests for E. coli in 2014 (June and October). There was some correspondence in the records about multiple antibiotic treatments.

	This lack of a proper history led to Mrs Morrison being prescribed antibiotics both by way of prophylaxis and treatment which were not going to serve their purpose. The court found this to be a serious omission.
5	**CORONER'S CONCERN** During the course of the investigation my inquiries revealed matters giving rise to a 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 -- a) The evidence showed that there was insufficient system to ensure the collation of an appropriate antibiotic history. The Hospital Trust concerned avows that it has rectified this issue but it seems likely that many other hospitals may be in the same position if patients are coming from a distance. b) Reference to the Code of Practice under guidelines issued both by Public Health England and the Dept of Health " The Prevention and Management of Infection" are quite clear that an antibiotic history is important. Consideration might be given as to whether Trusts should have a requirement to follow this, and whether further suitable DH guidance should be put in place. I therefore make this report.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the named authorities, 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 25th April 2018. I may extend this period upon request. 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 family of Mrs Morrison. Copies have also been sent to the Care Quality Commission, the relevant Clinical Commissioning Group and the Chief Executive of the Sheffield Teaching Hospitals Trust. 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.

Professor Christopher P Dorries OBE

26 February 2018