	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] 2. [redacted] 3. [redacted] Solicitors for family 4. Mr Simon Wright 5. Dr Simon Chapple 6. [redacted]
1	**CORONER** I am Mr Heath Westerman, Assistant Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 4th October 2017 I commenced an investigation into the death of Patricia Violet PALIN, dob 3rd November 1936. The investigation concluded at the end of the inquest on 6th June 2018 and the conclusion was one of Natural Causes. The medical cause of death was 1a. Sepsis 1b. Cellulitis Right Leg 2. Liver Cirrhosis, Hypertension, Ischaemic Heart Disease, Old Age.
4	**CIRCUMSTANCES OF THE DEATH** On the 1st October 2017, the deceased's family called Shropdoc twice at 09.18 hours and 14.32 hours. On the second occasion urgent care practitioners were required and they attended the deceased within 90 minutes. The deceased was assessed as not requiring hospital admission. The deceased's family made a 999 call to West Midlands Ambulance Service at 21.02 hours, the ambulance attended at 21.09 hours. At 21.13 hours the deceased had a EWS of 5. She arrived at The Princess Royal Hospital at 21.41 hours. She was triaged at 22.00 hours and had a EWS of 8. Sepsis was not deemed to be present. This was reviewed by a nurse and changed some 30 minutes later. That nurse spoke to a middle grade Emergency Department Doctor who authorised intravenous fluids to be administered. Her medical records were then placed into the wrong folder and she was not therefore reviewed by an Emergency Doctor until midnight when [redacted] came on duty. There had only been two Doctors on duty prior to that as one reported in sick. Bloods had been taken at 22.15 hours but no blood cultures were obtained. The blood results were known at 22.41 hours, they indicated that sepsis was present and that her kidney had been damaged and that her prognosis was poor. A urinary catheter was inserted at 01.00 hours. Intravenous antibiotics were prescribed at 00.30 hours but the drug Ertapenem was not in stock and when some was located it was not administered until 02.55 hours. At no point was oxygen administered. At 03.48 hours the deceased suffered a peri-arrest and died at 05.40 hours. The dressings on her legs had remained in place all day on the 1st October 2017, they were only removed at 02.20 hours on the 2nd October 2017 so that an examination of them could take place.

	The care provided by The Princess Royal Hospital on their own admission was sub-optimal; there was delayed recognition by the triage system; guidelines concerning sepsis were not followed meaning time critical management of the condition was delayed; sepsis six care bundle was therefore not followed through as it should have been. Had it been followed through in compliance with the guidelines it would have been to her benefit, however she was so poorly upon admission that it would not have altered the eventually outcome, indeed it would have prolonged it.
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. – 1. Shropdoc personnel, be that Doctors or Urgent Care Practitioners are not able to access the referring patients GP records. This meant that they did not have the full picture of Patricia's past medical history before administering any advice or treatment. This is not a one off isolated incident and applies to every case that is referred to Shropdoc. Evidence was given at the inquest from the Shropdoc Urgent Care Practitioners that it would have assisted them. 2. During the evening of the 1st October 2017, there were only two A&E Doctors on duty (a third had telephoned in sick). Too few Doctors were therefore on duty in general to cover patient needs and there did not seem to be in place a programme for trying to get a third Doctor to replace the Doctor who had telephoned in sick. 3. I heard evidence that a prescribed drug Ertapenem was not in stock within the A&E department and that led to a delay of some two hours and twenty five minutes until administration. Other suitable alternative drugs were available but not considered. 4. Whilst there was a general awareness of the dangers of sepsis from the Shropdoc and Hospital witness evidence; a. Red flag signs of sepsis were missed. b. Leg bandages were not removed to allow full top to toe examination. c. Sepsis six care bundles were not followed in accordance with guidelines.

6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 14th August 2018. 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] Solicitors for the family Mr Simon Wright, Chief executive of Shrewsbury and Telford Hospital NHS Trust Dr Simon Chapple, Medical Director of Shropdoc [redacted] Director of Shropshire Public Health
9	H. Westerman <u>Mr Heath Westerman</u> <u>Assistant Coroner</u> <u>Shropshire, Telford & Wrekin</u> 19th June 2018