East London Coroners
MISS N PERSAUD
SENIOR CORONER
Walthamstow Coroner's Court, Queens Road Walthamstow E17 8QP
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REF: 9030

16th June 2019

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Alwen Williams CEO Barts Health NHS Trust, The Royal London Hospital, Whitechapel Road, Whitechapel, E1 1BB** **And** [redacted]**Medical Director, Newham Co-operative, Royal Docks Medical Practice, 21 East Ham, Manor Way, London, E6 5NA**
1	**CORONER** I am Miss N Persaud Senior Coroner for **East London**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 26/11/2018 I commenced an investigation into the death of Shahida Begum. The investigation concluded at the end of the inquest 13th June 2019. The conclusion of the inquest was a narrative conclusion: *Mrs Begum presented with signs and symptoms that should have triggered further clinical observation and investigation on the 9 July 2018. She was diagnosed with muscle sprain and no further investigation was undertaken at that time. She then presented to hospital on the 10 July 2018 with signs of obvious sepsis. Despite treatment at this time, she passed away from the effects of an invasive Group A streptococcal infection. Had she received further observation and investigation on the 9 July 2018, it is likely that her death would have been avoided.*
4	**CIRCUMSTANCES OF THE DEATH** Mrs Begum became unwell on the evening of the 3 July 2018. She was unable to obtain an appointment with her registered GP and visited an out of hours GP on 6 July 2018. This GP diagnosed a urinary tract and throat infection and commenced treatment with trimethoprim and ibuprofen. Mrs Begum continued to deteriorate and on the 9 July 2018 she attended A&E. She was streamed by a doctor who directed her to the GP co-operative. The clinical streaming took place before her vital observations were taken. The streaming doctor later became aware of the observations, but did not change his decision to direct her to the GP. Her observations in A&E at that time should have triggered referral to A&E, where further observation and investigation should have been carried out. Instead, she was assessed by a GP

	who diagnosed muscular sprain and prescribed pain-killing medication. This GP should have recognised the need for further monitoring and review and should have directed her to A&E. On the 10 July 2018 she collapsed in her GP surgery and was taken as an emergency to hospital. She was found to be in obvious sepsis and despite treatment at this time, she passed away from an invasive group A streptococcal infection. She passed away in Newham University Hospital on the 10 July 2018.
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 **MATTER OF CONCERN** is: The current system in place at Newham University Hospital is that a clinical streamer will make a decision about the destination of the patient (GP clinic; urgent treatment centre or A&E), before clinical observations are taken by the triage nurse. The decision is based upon an "eyeballing" check of the patient and a brief history from the patient. It was considered by myself, (as Coroner), by an independent emergency medicine expert and a senior doctor from Newham University Hospital that a safer system would be for the streamer to have the clinical observations available to them before they see the patient.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe both organisations - Barts Health NHS Trust and the Newham Co-Operative, (working together) - 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 **13th August 2019.** 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] husband); [redacted] I have also sent it to Mr Matthew Cole (Director of Public Health) and the CQC, who may find it useful or of interest. 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	18/06/2019 Signature Miss N Persaud Senior Coroner **East London**