Ms N J Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Public Health England Yorkshire and the Humber Region,** [redacted] Centre Director, Blenheim House, West One, Duncombe Street, Leeds, LS1 4PL
1	**CORONER** I am Ms N J Mundy, Senior Coroner for South Yorkshire (East District)
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 12th November 2018 I commenced an investigation into the death of Zona Ethel Tebbs, 88. The investigation concluded at the end of the inquest on 19 July 2019. The conclusion of the inquest was Narrative conclusion. "*On 23 September 2018 Zona Ethel Tebbs sustained a garden injury for which she sought medical advice the following day. Failure to provide immunoglobulin on 24th September exposed her to a greater risk of developing tetanus and thus exposed her to a greater risk of death. As it was Mrs Tebbs was admitted to hospital with tetanus on 2 October 2018. Her clinical course was complicated by acute on chronic myelopathy. She passed away in hospital on 5th November 2018 from a combination of both these conditions*"
4	**CIRCUMSTANCES OF THE DEATH** Mrs Tebbs was a fit and active 88 year old lady in good health. On the 23rd September 2018 she Sustained a minor injury to her shin from a garden pick. The following day she attended her general practitioner where the wound was dressed and she was given the tetanus vaccination. On the 2nd October she was sufficiently unwell that an ambulance was called and she was taken to Doncaster Royal Infirmary. She was displaying early signs of tetanus but it was not diagnosed at the time and she was discharged. She returned to hospital by ambulance on the 3rd October where tetanus was raised but felt to be unlikely on the basis that this was a very rare condition and other differential diagnoses were being explored. It is clear however that the clinical signs were consistent with tetanus. One of the witnesses from the hospital told me that he was reassured by the fact that Mrs Tebbs had been given the tetanus vaccination by her GP. On the 4th October her symptoms had worsened, tetanus was diagnosed and treatment commenced. Following the diagnosis there was consultation with the Infectious Diseases Unit at the Sheffield Trust and further research undertaken into the condition. As a result of these various enquiries it was established that Mrs Tebbs needed immunoglobulin which was administered to her the same day. During the course of the admission the spasms improved but she was suffering from muscle stamina and following an MRI a diagnosis of likely acute on chronic myelopathy with recovery considered extremely unlikely. Mrs Tebbs passed away on the 5th November 2018. Her cause of death was 1a. Generalised tetanus and acute on chronic myelopathy.

	I heard evidence from a number of hospital doctors involved in treating Mrs Tebb's condition and also from [redacted] the general practitioner from the surgery concerned. The evidence included details of the way in which critical information is communicated by Public Health England to Primary Care practitioners and a lack of clarity and direction for those involved in Primary Care Delivery as to key changes. Concerns were raised regarding inadequate and ineffective communication of such matters; specifically with regard to the current case, I was provided with evidence (supported by documentation I detail below) that there had been significant changes to the definition of a tetanus prone wound and also changes to management of the same. Specifically, I was referred to an email from Public Health England of July 2018 entitled "Vaccine Update" which highlights that month's additional features which included "tetanus specific immunoglobulin (TIG) supply shortage". There was nothing in that email to alert practitioners to the fact that the definition of tetanus prone wounds had changed nor the management had changed which must be critical features which ought to have been highlighted. I was told by [redacted] that in order to extract that information she had to click on the link in the email, then click on a further link which took her to the document and then she had to read through a significant amount of the document to find the part that dealt with matters I have referred to above. She said a further issue was that most (if not all) primary healthcare practitioners refer to the Green Book guidance which had not been updated in line with the July 2018 email. The final part of this evidence was that further guidance was circulated in November 2018 and that the Green Book was updated at this time. As I was told that Primary Care practitioners receive significant number of email communications at any given time, it would seem essential to bullet point the key aspects of any such circulations thus pointing the practitioners in the right direction and enabling them to research further the matters being raised. I find it concerning that there was no bullet point of the change in definition of a tetanus prone wound or there had been a change to its management and it certainly caused difficulties for those treating Mrs Tebbs. The need for tetanus vaccination was identified by the GP practice but given the circumstances set out above it was not appreciated that Mrs Tebbs also needed the immunoglobulin and this omission may well have played a part in her demise. As I have recorded in my conclusion the failure to give her immunoglobulin in line with the updated guidance exposed her to an increased risk of developing tetanus. The final point of evidence was that GPs within the Doncaster borough have expressed frustrations at poor communication from Public Health England and that the instance I have described above in terms of that level of communication and extends more widely from this single issue. I consider that the failure to appropriately identify and effectively communicate key changes which effect medical practices and patients will continue to put patients at risk thus I considered a Prevention of Future Death Report was indicated.
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) Failure to effectively communicate key changes in clinical practice and advice e.g. an amended definition of a tetanus prone wound in the Public Health England email of July 2018 entitled Vaccine Update (attached).

	(2) Requiring Primary Care practitioners to click through a number of links and documents to try and unearth key pieces of information carries with it the risk that that information will be overlooked if key issues have not being identified in the covering email. (3) A failure generally to identify key issues in any updated in medical practice and communicate those effectively to those healthcare professionals involved in delivering such care. (4) Failure to update Green Book Guidance.
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 **Friday 13 September 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: The Department of Health, [redacted], St John's Group Practice, Medical Protection/CMS, DAC Beachcroft LLP. 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	Dated 19 July 2019 Signature_____ Senior Coroner for South Yorkshire (East District)