	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive, Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, ST4 6QG**
1	**CORONER** I am Sarah Murphy HM Assistant Coroner for **Stoke-on-Trent & North Staffordshire Coroner's Court**
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 06/08/2020 I commenced an investigation into the death of Michele Brenda Duckworth, aged 57. The investigation concluded at the end of the inquest on 9th February 2021. The conclusion of the inquest was that death was due to natural causes against a background of complications from necessary immunosuppression therapy and long term urinary catheter resulting from a road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a medical history of paraplegia from a spinal cord injury due to a road traffic collision in 1984. This resulted in a requirement for intermittent self-catheterization and she suffered recurrent urinary tract infections. She had end stage renal failure and underwent a renal transplant in September 2015 where she was then placed on immunosuppression therapy. She developed chronic diarrhoea and was under investigation at the Royal Stoke University Hospital, Stoke-on-Trent. She required two hospital admissions in October and December 2019 due to worsening of this condition. She was seen by the gastroenterology department on both hospital admissions and was referred for an outpatient appointment for a further investigation but the procedure was cancelled because of her clinical condition. She had suffered weight loss and malnutrition and had been referred to the dietician during her hospital admissions where supplements were offered and trialled in October but NG feeding had been refused. She declined supplements in the December admission and had capacity to make this decision. She was admitted to the renal ward of the University hospital on the 10th February 2020 with profuse diarrhoea and low blood pressure. She was treated with antibiotics, fluids and electrolyte replacement, blood transfusion, nutritional support and pancreatic enzymes supplements. She was clinically stable until the 21st February but then suddenly deteriorated on the 22nd February where she developed a temperature. Previous rectal swabs had shown that she was colonised with ESBL but current rectal swabs were negative. She was treated for sepsis with Tazocin but Trust guidelines in these circumstances required a different antibiotic. This did not contribute to her subsequent death. She was transferred to the Intensive Care Unit but was not suitable for ventilation. Despite further treatment, she deteriorated and died at 3.10pm on the 23rd February 2020. A blood culture taken on the 22nd February found Escherichia Coli bacteraemia which was resistant to Tazocin. The result of the blood culture was not known until after she had passed away. A post mortem examination found that death was due to sepsis from Escherichia Coli bacteraemia of an unknown source. Sepsis (Escherichia Coli bacteraemia) of unknown source.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The deceased was incorrectly prescribed Tazocin when she was previously colonised with ESBL. It was initially prescribed when she was on the renal ward and was continued when she was transferred to the Intensive Care Department. The antibiotic given in that context was not the antibiotic suggested in the trust guideline, and it was missed after several medical reviews.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 21st April 2020. 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: 1. [redacted] (Son of deceased). 2. [redacted] (Deputy Head of Legal Services, Legal Services Department, Royal Stoke University Hospital) I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	12/02/2021 Signature_____ Sarah Murphy _____ Sarah Murphy HM Assistant Coroner **Stoke-on-Trent & North Staffordshire Coroner's Court**