NHS
Lewisham and Greenwich
NHS Trust

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[redacted]

Please cc to IPs
22/6

HMSC Andrew Harris
Southwark Coroners Court
1 Tennis Street
London
SE1 1YD

10 June 2021

Dear Coroner Harris

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Re: Mr YUSUF SEYIT

I am writing in response to your report dated 16 April 2021, concerning the care provided to Mr Seyit. Your report highlighted two matters of concerns which are listed below.

1. Mr Seyit was known to be at high risk of fatal infection and had developed symptoms two days before death and definitive proof of infection by the late afternoon of 2nd July 2020, but it was not clear whether there was a plan for antibiotic intervention and no treatment was commenced that day.

2. When in septic shock in the early hours of 3rd July 2020, three antibiotics were prescribed, and the Trust initial death report indicated treatment had commenced before he died. However, the medical records available to the inquest did not confirm when Amikacin was actually administered. Evidence provided by a consultant physician confirmed that it needed to be within an hour.

As a result, the Trust is required to ensure the appropriate antibiotics for septic shock are prescribed and administered within the hour at all times irrespective of the time of day.

Following receipt of this report, the Trust completed an internal review of the incident and confirmed that Mr Seyit was prescribed antibiotics at 07:00hrs, which were administered at 07:49hrs which was within the hour. We acknowledge and apologise that The Trust did not provide the appropriate evidence required during the inquest.

However, the Trust has taken the opportunity to review its current practices around sepsis and take the following steps:

1. The Trust and Division have re-audited sepsis performance on all clinical wards against the Sepsis 6 Bundle Standards and actions have been taken to improve gaps in practice. This will be monitored through our internal governance processes.

2. The Trust will ensure that all wards are adequately stocked with the paper version of the Sepsis Assessment Bundle, and all clinical staff have been reminded that prescribed critical medications are to be administered to patients within an hour of being prescribed by a doctor. This is discussed at Ward Safety huddles and local team meetings.

3. The Trust is prioritising the implementation of an electronic (iCare) Sepsis Bundle. This was originally scheduled for 2022. Discussion have taken place with the Trust IT department and there are plans for this to be completed later this year. This will be monitored via Divisional Governance processes and assurance given via the Trust Quality and Safety Committee.

I would like to assure you that the Trust has taken the concerns raised seriously and learning from this incident has been shared at the Trust Mortality Review Committee, Divisional Mortality and Morbidity and the Junior Doctors review meetings.

Should you have any further questions regarding any of the information provided in this letter or require any furtherinformation please do not hesitate to contact me.

Yours sincerely

Dr [redacted]
Medical Director
Lewisham and Greenwich NHS Trust