HM Coroner
County of Cumbria
Regulation 28

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Lyn Simpson, CEO North Cumbria Integrated Care Trust, The Pillars Building, Cumberland Infirmary, Carlisle**
1	**CORONER** I am Dr Nicholas Shaw Assistant Coroner for **County of Cumbria**
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 18/02/2020 I commenced an investigation into the death of Allan Arthur Watt. The investigation concluded at the end of the inquest 28th May 2020. The conclusion of the inquest was Allan Arthur Watt had become increasingly unwell over several months despite multiple medical interventions. He was eventually admitted to Cumberland Infirmary, Carlisle where he was found to have an ischaemic bowel, The condition was inoperable and led to his death on 20th September 2019. Only at post mortem examination was the cause was found to be systemic vasculitis.
4	**CIRCUMSTANCES OF THE DEATH** Relatively fit and well 61 year old joiner up until 3 weeks prior to his death. Patient lost 3 stones in the 3 weeks leading up to his death. Became ill in August and was self-admitted to CIC. Initial tests suggested possible polymyalgia or liver disease. Patient discharged back to H/A for GP follow up. Second admission to A&E. Discharged with another diagnosis of possible polymyalgia. GP could not confirm polymyalgia. She also suspected some form of liver disease, or Lyme disease. Still no official diagnosis. Seen by GP 16/09/19. Patient had had hiccups for 3 days. GP said that if tests showed an underlying cancer the patient would be dealt with under the 2 week rule (fast track admission treatment etc.). GP expected further CIC investigation. Thursday 19/09/19 patient's foot went numb and he became very hot. GP contacted who said call 999. Acute admission to CIC. Kept in A&E until early hours, still no diagnosis. Wife told that Allan would go to the ward later that morning and she should go home and get some sleep. She attended Larch D the following afternoon to be told by a Consultant that half of her husband's bowel was necrotic/diseased and death was imminent. He also said that this should have been diagnosed a lot earlier than it was and as such the patient could have been saved. Alan passed away later that evening. Family were then told that the Coroner would be informed and to expect contact from them. The hospital did not refer the case to the Coroner or the police. The Coroner only found out when the funeral director rang us for an update. Independent PM required in case this case goes to inquest.

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) Mr Watt arrived at A&E at 8pm, he was seen within an hour by a nurse practitioner and admission arranged. However after he got onto the ward at 2am he did not see a doctor to be clerked in until 10.30. Both Allan's family and I as coroner felt this delay was unacceptable. (2)After Allan had been clerked in and IV fluid and antibiotic advised he did not receive an IV line or a first dose of antibiotic until 3pm –it was now 19 hours after he had arrived in A&E and in that period he had received no fluid or drug treatment. (3)Allan died at 18.45, evidence suggested that he may have been too ill to survive even at the time he arrived in the A&E department but I have no doubt that the want of timely assessment and treatment denied him any chance at all. It is my hope that attention to these concerns will indeed prevent future deaths at your hospital.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Lyn Simpson 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 **5th August 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 Interested Persons in the case. 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	03/06/2020 Dr Nicholas Shaw Assistant Coroner **County of Cumbria**