REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care, Tameside and Glossop Integrated Care NHS Foundation Trust
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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
3	INVESTIGATION and INQUEST On 20th January 2022 I commenced an investigation into the death of Ernest Bacon. The investigation concluded on the 26th July 2022 and the conclusion was one of **Narrative: Died from sepsis contributed to by the complications of an accidental fall.** The medical cause of death was **1a) Sepsis; 1b) Bronchopneumonia; II) Fractured Neck of Femur, Chronic Obstructive Pulmonary Disease, Ischaemic Stroke**
4	CIRCUMSTANCES OF THE DEATH Ernest Thomas Bacon had an accidental fall at his home address. He was admitted to Tameside General Hospital where it was identified he had a fracture to the neck of femur. He was operated on. He had an ischaemic stroke whilst an inpatient. On 16th January 2022 at 19:50, his NEWS score was recorded as 7. He was prescribed fluids but not intravenous antibiotics. The Trust Policy was not followed in relation to intravenous antibiotics being given within 1 hour. He was not given intravenous antibiotics until about 22:38. The decision not to follow the Trust Sepsis Policy was not recognised and not escalated. He continued to deteriorate. On 17th January 2022 he died from Sepsis at Tameside General Hospital.

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. The Inquest heard that when Mr Bacon became unwell on 16th January the Trust was staffed at weekend/OOH doctor numbers. This meant that there were a very limited number of doctors available within the hospital when the ward staffed asked for a clinical review when Mr Bacon triggered for sepsis on the NEWS2 system. The Inquest heard that the staffing numbers of doctors and reliance on junior doctors at weekend to cover the wards is part of the national staffing model; 2. As a consequence of the availability of doctors he was not reviewed face to face but via telephone. His notes were not seen. The seriousness of his condition was not recognised and he was not flagged up on handover; 3. The Trust Policy required he be treated for Sepsis. However he was not placed on the Sepsis pathway and a further review did not take place until a further doctor was asked to examine him at about 22.30 despite his NEWS2 score continuing to trigger for Sepsis; 4. The nursing team recognised that he was triggering for Sepsis but the notes were not flagged and the failure to follow the Sepsis policy was not escalated in accordance with Trust Policy. The reason for non-escalation was unclear.
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 1st October 2022. 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 namely [redacted] on behalf of the Family, 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	**Alison Mutch** **HM Senior Coroner**  **06.08.22**