KALLY CHEEMA
SENIOR CORONER

County of Cumbria

Fairfield
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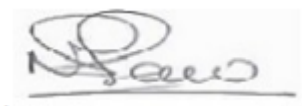
Cockermouth, CA13 9PT

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: [redacted], **Chief Executive, North Cumbria Integrated Care Trust.**
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: https://www.legislation.gov.uk/ukpga/2009/25/contents http://www.legislation.gov.uk/uksi/2013/1629/contents
3	**INVESTIGATION and INQUEST** On 26th January 2022, an investigation was commenced into the death of Gordon Bernard Hendley The inquest was opened on 10th May 2022 and concluded on 13th July 2022 The medical cause of death was: 1a Stevens-Johnson Syndrome 2 Angioimmunoblastic T cell lymphoma, Pulmonary Embolus and Lung Abscess The determination was: Gordon Bernard Hendley died in Cumberland Infirmary, Carlisle on 23rd January 2022. He had been severely ill for two months with lung embolism and infection on a background of a treated lymphoma which may have been relapsing. He developed a severe rash with difficulty eating and drinking, most likely Stevens-Johnson Syndrome. Late on 20th January he was admitted to the hospital A&E department where he spent 6 hours awaiting assessment by a doctor and a further 12 hours until a bed was found for him on a ward. The significance of a blood test was not escalated and by the time Gordon was admitted to the Intensive care unit some 24 hours after arrival at the hospital he failed to respond to maximal treatment and sadly died. The conclusion of the inquest was: Death due to a severe reaction to necessary medication. A significant delay in medical assessment and treatment is likely to have contributed.
4	**CIRCUMSTANCES OF THE DEATH** Gordon had been treated for lymphoma but there were concerns it was relapsing. In November/December 2021 He spent a month in hospital with a chest infection and pulmonary embolism. He was readmitted in January 2022 and found to have an abscess in the damaged lung. He had been treated for this but developed an allergy to the initial antibiotic which was changed when he was discharged on 14th January. On 19th January

	his GP referred him back to hospital with worsening rash particularly affecting the mouth suspecting a diagnosis of Stevens-Johnson Syndrome (SJS). He was referred to the Same Day Emergency Clinic, seen by a medical registrar and sent home again on an increased dose of steroid with an urgent outpatient appointment for dermatology on the 21st Gordon deteriorated at home and was admitted to the emergency (A&E) department late on the evening of 20th January. He was triaged by a nurse but not seen by a doctor for 6 hours, a blood test was performed but the result was not escalated to a consultant, some basic treatment was given in A&E and after a scan he was referred to medicine & surgery, seen by surgical registrar and by his haematologist and a medical consultant. Eventually he was taken to a medical ward in the evening where he was found gravely ill by an intensive care doctor who had been asked to help insert a drip. The ICU consultant was informed and immediately took Gordon onto the unit but sadly he died at 6.30 am on 23rd January despite maximal treatment.
5	CORONER'S CONCERNS 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) Stevens-Johnson Syndrome is a dermatological emergency with a significant mortality rate (perhaps over 10% in a man of Gordon's age and frailty), he was referred with this diagnosis by an experienced GP. While evidence suggests a medical consultant was contacted he did not see Gordon himself and I heard no evidence to suggest a dermatologist was consulted for advice. Also the SCORTEN or ABCD-10 prognostic tools were not used, they may have been helpful. 2) When Gordon returned to A&E late on 20th January there was an excessive delay in his assessment. His blood test revealed a significant lactic acidosis with marked anaemia and very low white blood counts. The A&E consultant who gave evidence said she would have expected this to be escalated to her -she was on call at home, but it was not. I have inputted the data in medical records to the scoring tools referred to above and mortality predictions have now risen to around 50%. 3) Gordon had a CT scan, he was referred to medicine but not seen by a medical consultant until 4.30 pm, he was to be admitted to a ward (this happened at 6.30pm) but there is no record in the notes of the significance of the earlier blood test being appreciated. 4) At the inquest into the death of Nicholas Dietzold (who died in the A&E department) which I heard last September I was assured that a system of "Intentional Rounding" would take place in A&E when a senior doctor and nurse would go round the department to look at patients & assure themselves that appropriate actions were in hand (I am aware the design of the department is less than ideal). The consultant gave evidence assuring me that this did take place but there were no notes to confirm this and I question whether it is a robust system. 5) On the medical ward there still seems to be no sense of urgency in Gordon's treatment. A further blood test at 8.45pm showed severe lactic acidosis and hyperkalaemia but no action seems to have been taken. It was not until the ICU doctor happened upon Gordon just before 11pm, 24 hours after he arrived in the hospital that positive steps were taken.

	6) [redacted], Gordon's wife was not permitted to be with him in A&E due to Covid restrictions. Thus he had no advocate. I have no doubt that had she been there to speak for him care would have been expedited. It is my view that regardless of policy severely ill patients will benefit from support in similar circumstances. 7) I was shown a "Mortality and Harm Review Tool" completed in May which concluded that "care was good and decisions sound", and that there was no need for a Serious Incident Review. I stated in court that I completely rejected this. I did however note and am pleased that [redacted] is producing an educational programme and Standard operating procedure for SJS/TENS.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the Trust has 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 9th September 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: [redacted] Gordon's widow. I am also sending copies to the Care Quality Commission and [redacted] of Caldbeck Surgery who may find it useful. I will also be using the "Yellow Card" system to report this case to the MHRA. 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	14 July 2022  Dr Nicholas Shaw HM Assistant Coroner County of Cumbria