REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] Medical Director North Manchester General Hospital Delaunays Road, Manchester M8 5RB Copied for interest to: • [redacted] – the deceased's son on behalf of other family members
1	**CORONER** I am: Senior Coroner Nigel Meadows Senior Coroner for Manchester City Area HM Coroner's Court and Office Exchange Floor The Royal Exchange Building Cross Street Manchester M2 7EF
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 the 16th July 2019 I commenced an investigation into the death of. The investigation concluded on the 11th November 2021. The Conclusion of the inquest was**: Natural Causes:**

Circumstances of the death

The deceased was 78 years of age and suffered from ischaemic heart disease. On the 3 July 2019, she had a dental procedure to extract a tooth. She developed a condition called dry socket and she had further dental treatment on the 4 July 2019.On the 5 July 2019 she attended an urgent GP appointment and was noted to have significant swelling in the jaw area and was suffering considerable pain. There was a malodour less smell and she was barely able to open her mouth.
The GP diagnosed that she was suffering from red flag symptoms of sepsis and contacted North Manchester General Hospital ("NMGH") who advised her to attend A&E urgently because she would require further clinical assessment and appropriate treatment. At the time in NMGH was operated by the Northern Care Alliance group of NHS trusts ("NCA"). It had existing policies and protocols which staff should be aware of and follow in a case of suspected sepsis. There had been previous reported incidents where concerns arose about failures to recognise and treat sepsis in a timely manner.

She arrived at NMGH at about 16:14 hours accompanied by a family member who handed a letter to the receptionist from the GP explaining his findings and the "red flag" signs of sepsis. This condition needs to be diagnosed and treated as soon as possible. The receptionist did not read the letter in full, but had she done so it would have alerted her to the need for urgent triage. Sepsis is a very serious infective process which can rapidly escalate and if not treated in a timely and appropriate manner is a life threatening or life ending condition. The severity of her illness and expected presentation was not communicated to the Registrar on call after the GP contacted the hospital.

She was not triaged within 15 mins and had not been assessed by about 17:00 due to a miscommunication between nursing staff when her condition deteriorated, and she had a cardiac arrest but was successfully resuscitated.

She was then examined by a maxillofacial surgeon who arranged for her to undergo emergency surgery which started at about 19:00. She had extensive surgery, but despite this her condition deteriorated, and she died at about 00:20 hours on the 6 July 019, and had suffered from necrotising fasciitis which was probably unsurvivable even with earlier triage, antibiotic treatment or surgery.

She had developed a rare but severe form of sepsis which led to the rapid death of tissues in the form of a severe infective process called necrotising fasciitis. By the time the inquest was heard in MMGH was operated by Manchester University Foundation NHS trust ("MFT"). However, the overwhelming majority of clinical and nursing staff who had previously worked for the NCA continued to work at NMGH for MFT who had their own policies and protocols concerning the identification and treatment of sepsis.

5 **CORONER'S CONCERNS**

The **MATTERS OF CONCERN** are as follows:

1. That MFT ensure that all their sepsis protocols and policies are up to date.
2. That all appropriate clinical and nursing staff are familiar with them and have necessary training and updates as required.
3. That new or locum clinicians as well as agency nursing staff are made aware of the sepsis policies and protocols and act in accordance with them.
4. Periodic audits are undertaken to ensure appropriate recognition of sepsis has been made and appropriate treatment commenced in a timely manner.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 the 31st 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 Interested Persons. I have also sent it to organisations 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	**DATE: 31st August 2022** **Mr Nigel Meadows** HM Senior Coroner Manchester City Area **Signed:**