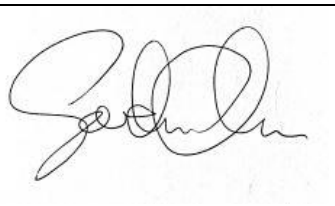
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** - **Nottingham University Hospitals NHS Foundation Trust** **Copies are to be sent to the family.**
1	**CORONER** I am Mr Gordon Clow, Assistant Coroner for the coroner area of Nottinghamshire.
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** An investigation was opened touching on the death of Carl Wright on 3 November 2021. The investigation concluded at the end of the inquest on 28 September 2022. The conclusion of the inquest was the short form conclusion that Carl Wright's death was from natural causes, with a supporting narrative as follows:- "There was sufficient information available for a suitably experienced doctor to ascertain that Mr Wright was suffering from an infection on or before 22 October 2021. This would have prompted investigations which would have identified the abscess earlier than 26 October 2021. This would, in turn, have improved Mr Wright's chances of survival. It is not possible to say, on the available evidence, whether or not Mr Wright would have survived had this taken place."
4	**CIRCUMSTANCES OF THE DEATH** On 4 June 2021 Mr Carl Wright underwent complex cardiac surgery against a background of previous stroke and other serious health conditions including diabetes mellitus, cerebrovascular disease and peripheral vascular disease. He suffered significant setbacks during and after the surgery and remained on the intensive care unit for approximately eight weeks. Mr Wright was transferred to a rehabilitation unit. The rehabilitation unit did not undertake the usual assessments and decision making prior to Mr Wright's admission. Mr Wright was not sufficiently well to be safely cared for on the rehabilitation unit and his postural hypotension rendered him unsuitable for that form of inpatient rehabilitation. The unit itself was not well suited to Mr Wright's particular needs. Whilst on the rehabilitation unit Mr Wright's medical condition was not reviewed very frequently. Blood samples taken on 14 October 2021 showed evidence of an infection. No doctor reviewed these results at the time and no further action was taken in response. On 20 October 2021 Mr Wright began to demonstrate symptoms consistent with, but not clearly typical of, an infection. The medical care available to Mr Wright on 20, 21 and 22 October 2021 was limited to input from an inexperienced junior doctor. A

	consultant could have been contacted by the junior doctor on the 20, 21 or 22 October 2021. The junior doctor did not contact a consultant for advice. Mr Wright's symptoms during this period were caused by an abdominal abscess. Routine investigations which would have led to an earlier identification of the abscess were not undertaken. At no time during this period did the junior doctor responsible for Mr Wright's care make any entries in the medical running records. This made it more difficult for other doctors to form a view about Mr Wright's medical situation. Mr Wright's medical condition was not reviewed as regularly as his condition indicated. The above factors delayed the diagnosis of Mr Wright's infection and abscess. Mr Wright then went on to develop sepsis in response to the infection in the following days. By the time Mr Wright's abscess had been identified, on 26 October 2021, he was too unwell, and the abscess collection was too irregular, for surgery or interventional radiology to be attempted. He was provided with appropriate care to maximise his comfort and then died on 29 October 2021.
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 could 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 majority of medical care, including the identification and assessment of deteriorating patients, was done by inexperienced junior doctors with no easy access to input from more experienced doctors; and (2) There was an established culture and practice of most blood tests results not being reviewed in a timely manner. Other areas of concern existed regarding other issues but plans were in place to address these areas and so I did not have ongoing concerns of a risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 13 December 2022. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting 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 set out above. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

	I may also send a copy of your response to any other person who I believe may find it useful or of interest. In this regard, I have sent a copy to the Care Quality Commission. 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.
9	 **Mr Gordon Clow, HMAC** **17 October 2022**