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**
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 22nd April 2022 I commenced an investigation into the death of Philip Geoffrey Day. The investigation concluded on the 19th October 2022 and the conclusion was one of **Narrative: Died from complications of necessary medical therapy**. The medical cause of death was **1a) Multi-organ Failure; 1b) Neutropenic Sepsis and Colitis; 1c) Methotrexate treatment of Psoriatic Arthritis**
4	CIRCUMSTANCES OF THE DEATH Philip Geoffrey Day had psoriatic arthritis. He was prescribed methotrexate for his condition. Blood tests on 10th April 2022 showed that he had neutropenia and a raised CRP. He was advised to go to hospital due to the risk of neutropenic sepsis a rare but recognised complication of methotrexate. He went to Stepping Hill Hospital. Triage occurred approximately 50 minutes after his arrival and he was reviewed by a doctor at 04.56 almost 7 hours after his arrival. Antibiotics and fluids were prescribed for his neutropenic sepsis. This was outside the recommended timeliness guidelines. He was admitted to Stepping Hill Hospital and continued to be treated for neutropenic sepsis. He developed ileitis and colitis. He continued to be treated. On 15th April the combination of the neutropenic sepsis and inflammation led to a cardiac arrest and multi organ failure. He died at Stepping Hill Hospital on 15th April 2022.

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. When Mr Day arrived in ED, it was struggling to cope with a large backlog. Waiting times on that night /morning were significant. Triage wait times were approximately 1 hour. The time to see a doctor rose through the night to 7 hours and 38 minutes by 6am. The inquest heard that this was due to sheer volumes and that this is a situation that still arises. The impact is a delay in patients being seen, assessed and treated promptly; 2. In relation to Mr Day the inquest heard that the community OOH Doctor had correctly recognised the risk of neutropenic sepsis and had rung through to speak to a doctor at the hospital. At the inquest there was no documentation to assist in tracking that conversation or any evidence it had been recorded or acted on. It was clear from the evidence at the inquest that the sharing of information between community clinicians and secondary care was important and that there appears to be no recognised way for this to happened due to varied IT systems and no national recommendations for best practice in this scenario. As a consequence vital information is not available to ED teams. 3. The Inquest heard that Mr Day's first EWS score in ED was 2. He did not trigger on EWS for sepsis. However the blood tests in the community had shown a very low neutrophil level and a rising CRP. Had those factors been recognised along with his immunosuppression then he would have been treated under the neutropenic sepsis pathway earlier. The evidence suggested that there is a lack of awareness of the guidance and red flags for neutropenic sepsis which delays treatment. Greater awareness and triage questions that prompt for neutropenic sepsis would reduce the risk of neutropenic sepsis symptoms being missed at triage.
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 **30th December 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 Mr Day's Family and Browne Jacobson Solicitors, 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 OBE** **HM Senior Coroner**  **04.11.2022**