Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Milton Keynes University Hospital Litigation**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
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 03 November 2021 I commenced an investigation into the death of Michael ALLEN aged 56. The investigation concluded at the end of the inquest on 02 November 2022. The conclusion of the inquest was that: Mr Michael Allen died on the 11th April 2021 at the Milton Keynes University Hospital. He was admitted on the 3rd April 2021 with gallstone pancreatitis. Subsequent to ERCP removal of the obstructing gallstone there were missed opportunities on the 9th April 2021 to recognise that he was developing sepsis and also then to manage it effectively.
4	**CIRCUMSTANCES OF THE DEATH** Mr Michael Allen was an otherwise healthy man who developed gallstone pancreatitis and was admitted to Milton Keynes University Hospital on the 3rd April 2021. He died on the 11th April 2021 from 1a Acute pancreatitis and liver necrosis resulting from 1b Gallstone disease (ERCP 8th April 2021). Had he been effectively monitored and subject to senior surgical supervision during the 9th April 2021 it is more likely than not that he would have survived.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) An FY1 doctor was effectively left to her own devices to manage Mr Allen, despite her being only 8 months or so in a post qualification position. In my mind this was a wholly unacceptable lapse on the part of her senior clinicians. She was, despite her efforts, out of her depth. This is not a criticism of the FY1 doctor, simply a reflection that she had only a few months junior surgical experience at that time. All clinicians, [redacted] gave evidence that they were aware of the MKUH Sepsis protocol. However, none of them was able to describe it fully – the nearest being the most junior of the team, [redacted].

	As a result there was a failure to initiate the sepsis protocol effectively. There was no effective senior involvement in the care of Mr Allen from the end of the 0800 am ward round to his deterioration at around 1800 or so. There was a failure to effectively or consistently monitor Mr Allen between 1059 am and his deterioration around 1800. Even at that point despite, in my mind, a critical emergency, there was a further delay of one hour before the ITU team were called. Overall, I find that the surgical team in charge of Mr Allen had no effective knowledge of the Sepsis protocol, they failed to monitor him effectively or consistently despite clear signs of deterioration, they failed to provide adequate support and supervision to [redacted] and they failed to institute an effective senior review at any point on the 9th April 2021 until critical deterioration by which time his chances of death due to his rapid deterioration and multi-organ failure were 80 to 100%.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 5th April, 2023. 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] [redacted] [redacted] I have also sent it to **Milton Keynes University Hospital Litigation** who may find it useful or of interest. 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 person who I believe may find it useful or of interest. 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	**Dated: 19/01/2023** **Sean CUMMINGS** **Assistant Coroner for** **Milton Keynes**