REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Tameside and Glossop Integrated Care NHS Foundation Trust and NHS England
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 3rd January 2023 I commenced an investigation into the death of Jane Elizabeth Wadsworth .The investigation concluded on the 12th June 2023 and the conclusion was one of Narrative: Died from the complications of elective surgery where antibiotics were not always administered in accordance with her prescription and her deteriorating condition was not assessed by Intensive Care clinicians until 31st December despite her poor liver function, poor kidney function and worsening condition. The medical cause of death was 1a) Sepsis; 1b) Cellulitis; II) Elective Hip replacement performed on 13/11/22, Deep Vein Thrombosis, Adult Polycystic Kidney Disease with Liver Cyst, Acute Kidney Injury, Ulcer Left Foot

4	CIRCUMSTANCES OF THE DEATH Jane Elizabeth Wadsworth had elective hip surgery. She returned to Tameside General Hospital with concerns over her wound. She subsequently developed a deep vein thrombosis and cellulitis. On 22nd November 2022 she became very unwell and was admitted to Intensive Care Unit with sepsis, acute kidney injury and liver failure. She was treated on the Intensive Care Unit until 26th November when she returned to the ward. She continued to be treated for her cellulitis and an ulcer of the left foot that had developed. She was stepped down to the Stamford Unit on 16th December 2022. On 22nd December 2022 she returned to Tameside General Hospital due to concerns about her raised NEWS 2 score, raised probably as a consequence of cellulitis. She was started on intravenous

	antibiotics. Her liver function was deranged and she had acute kidney injury. She had a catheter but her urine output was difficult to assess due to issues regarding possible catheter bypass. On 24th December, one dose of antibiotics was missed. On 25th December, two doses of antibiotics were missed. She continued to be unwell and on 27th December further antibiotics were prescribed. She was referred to the Critical Care Outreach Team who assessed and determined that Intensive Care Unit referral was not necessary. On 29th December the antibiotics were changed. There was a further referral to Critical Care Outreach that was unsuccessful as there were no staff available. There was no doctor to doctor assessment and no consultant review and no liver specialist advice sought or provided. She continued to deteriorate on 30th December with poor liver function and poor kidney function. On the morning of 31st December she deteriorated rapidly and was accepted by the Intensive Care Unit where despite aggressive treatment she deteriorated rapidly and died on 31st December 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. Mrs Wadsworth missed three doses of antibiotics prescribed to treat her infection according to the evidence given to the inquest. This did not appear to have been escalated and there was no clear explanation regarding this occurring other than that her cannula may not have been in place and there was a delay in a doctor being available to reinsert one; 2. The evidence before the inquest was that on her admission over Christmas/New Year there was no effective consultant input into her care; 3. The junior doctor involved in her care felt that ICU involvement/input would be beneficial. The evidence was that there did not seem to be any doctor to doctor discussion of this. The inquest heard evidence that this was one way a patient could be transferred to ICU. It was unclear why there had not been such a discussion and whether in periods such as Christmas/ New Year where there were fewer consultants available the system worked effectively. This was not a situation where there had been a ward based ceiling of care put in place and ultimately Mrs Wadsworth was treated by ICU but was extremely unwell at that point and did not respond to that intervention at that point; 4. The alternative support available to ward based staff and possible route into ICU according to the evidence given at inquest was via the Critical Care Outreach team. That team is staffed primarily by nurses and its key

	focus is on presentation linked to NEWS2 scores according to the evidence given to the inquest. Mrs Wadsworth's case was a complex one involving issues relating to her liver function and kidney function rather than just her NEWS2 scores and it was unclear if the Critical Care Outreach Team were best placed to assess her need for ICU support; 5. The inquest heard that on the date of one referral that team was not in any event available to the ward and the nurse who should have undertaken the role had been redeployed elsewhere in the trust and there was no capacity to fill that role; 6. Following her first admission to ICU there was a note that Mrs Wadsworth's case should be discussed with a specialist Liver team. There was no evidence available to the inquest that such a discussion had taken place. It was not entirely clear on the evidence precisely which clinician was to take ownership of the action.
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 11th September 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 namely [redacted] on behalf of the Family, 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 HM Senior Coroner  17.07.2023