MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
East London Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**, Chief Executive Officer, Barking, Havering and Redbridge University Hospital NHS Foundation Trust**
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 4 October 2022 I commenced an investigation into the death of Mr Matthew John Phipps, aged 56 years. The investigation concluded at the end of the inquest on the 26 June 2023. The conclusion of the inquest was that Mr Phipps died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On the 10 July 2022, Matthew Phipps was admitted to Queens Hospital with a severe, acute kidney injury and a 5 day history of fever, chills, diarrhoea and vomiting. On the 10 July 2022 he also presented with lower abdominal pain, lower back pain and pain in the top of his right leg. He was recognised as being critically unwell and the emergency department requested transfer

	to the intensive care unit. There was a delay in transferring Matthew to intensive care. He should have been transferred by 2230 on the 10 July 2022, but was not transferred until 0930 on the 11 July 2023. Matthew's family observed that only one of two bottles of antibiotics prescribed to Matthew in A&E were administered to him. Matthew was not observed as closely as he should have been, given his very concerning clinical condition and there were delays in carrying out necessary blood tests and in commencing renal replacement therapy. The inquest has found however that Matthew presented to hospital on the 10 July 2022 with a likely acute kidney injury, associated with sepsis. As such, his prognosis was very poor, even with optimal treatment. There is no evidence that the failings in the care provided to him contributed to his death.
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: A concern arose at the Inquest hearing in relation to the lack of a contingency plan in place to ensure that intensive care is provided to all patients who require it, but where the intensive care unit itself is full. The Inquest heard evidence from an independent consultant anaesthetist who stated: *I do not understand why one or two of the 8 ICU patients who were deemed to be wardable, could not have been moved elsewhere (e.g. to a post anaesthetic care unit in an operating suite), to enable a sick patient such as Mr Phipps to be admitted to the ICU. It is my understanding that most ICUs have such contingency plans in place, in the form of agreed standard operating procedures.* The Trust were aware of this concern, but did not provide any evidence to address this.
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 **25 August 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 family of Mr Phipps. I have also sent a copy to the local Director of Public Health who may find it useful or of interest and to the CQC. 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. 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	**29 June 2023**