MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref:

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **Chief Executive Officer, Barking, Havering & Redbridge, University Trust** [redacted] 2. **Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, senior 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 26th January 2023 this Court commenced an investigation into the death of Thomas Doyle aged 90 years. The investigation concluded at the end of the inquest on19th October 2023. The Court returned a narrative conclusion: "*Thomas Doyle died in hospital on 25th January 2023, he was admitted on 22nd January 2023 on a background of back and chest pain. Whilst undergoing diagnostic processes, Mr Doyle developed sepsis whilst in hospital which caused his death.*" Mr Doyle's medical cause of death was determined as;

	1.a. Sepsis 1.b. Bronchopneumonia, Pyelonephritis and Empyema of the Gallbladder 2. Hypertension, Frailty
4	**CIRCUMSTANCES OF THE DEATH** Thomas Doyle was a 90 year old man admitted to hospital on 22nd January 2023 with back and chest pain. He underwent a series of diagnostic tests. At admission Mr Doyle was found to be experiencing two factors that fall within the systemic inflammatory response syndrome criteria in defining severe sepsis - an elevated white blood cell count and tachycardia. Despite these findings and in contravention of the Trust policy, a diagnostic process required to confirm or eliminate a diagnosis of sepsis was not commenced at that time. Subsequently, there were a further two missed opportunities to commence the diagnostic pathway in the next 24 hour period. In the early hours of the morning of 24th January 2023 Mr Doyle suffered a significant drop in blood pressure, intravenous anti-biotics were commenced. Despite appropriate treatment, Mr Doyle continued to deteriorate and subsequently died.
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 trust's clinical records were of a particularly poor standard which impeded the Trust's governance investigation and the inquest investigation in determining what, if any consideration was given to the possibility that Mr Doyle was suffering from an infection. 2. The Trust's failure to commence a diagnostic pathway to investigate sepsis when clearly indicated on Mr Doyle's admission, as required by both local policy and national guidance.
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 **15th December 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 the family of Mr Doyle. I have also sent it to the local Director of Public Health 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 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	**[DATE] 20th October 2023 [SIGNED BY CORONER]**