REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Care Quality Commission** **2. [redacted], parents of the Deceased** **3. North Bristol NHS Trust** **4. Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Area Coroner, for the coroner Area of Avon
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 31st March 2022 I commenced an investigation into the death of Ms. Madeleine Lawrence age 20 years. The investigation concluded at the end of the inquest on 8th September 2023. The conclusion was that the medical cause of death was I(a) Multi organ failure; I(b) Group A Streptococcal sepsis; I(c) Streptococcal necrotising myositis; II Traumatic native hip dislocation and the narrative conclusion was 'Madeleine Laurence died of a rare complication of an infection which developed after she suffered an injury whilst playing rugby. In hospital her deterioration was not recognised and necessary life-saving treatment was not commenced promptly. Madeleine's death being contributed to by neglect.'
4	**CIRCUMSTANCES OF THE DEATH** On 9th March 2022 Ms. Lawrence was playing rugby when she suffered a traumatic native hip dislocation following a tackle. She was taken by ambulance to Southmead Hospital, Bristol where underwent reduction of the dislocation under general anaesthesia. The following day she developed pain in her hip and overnight from 10th to 11th March 2022 her condition deteriorated. Observations were not performed for several hours and when undertaken confirmed her NEWS score of 4. The frequency of the observations were not increased and the provisions of NEWS toolkit and the SEPSIS6 protocol were not followed. The NEWS score later increased to 5 and again observations were not carried in a timely manner and prompt treatment for presumed sepsis was not initiated. When Ms. Lawrence was reviewed on Monday 14th March 2022 it was recognised that she was seriously unwell and she was immediately transferred to the Intensive Therapy Unit. She was treated for sepsis and underwent a number of surgical procedures. Ms. Lawrence was diagnosed with necrotising myositis but despite all efforts her condition deteriorated and she died in hospital on 25th March 2022. During the course of my investigation I became aware that the NHS Trust had taken steps to increase awareness and training in the NEWS toolkit and the recognition and treatment of the deteriorating patient and sepsis in particular. The focus of the Trust's efforts had been the ward where Ms. Lawrence was accommodated but that training across the wider Trust was ongoing.

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) That serious deficiencies affecting the safety of patients at Southmead Hospital, Bristol which had been identified following the death of Ms. Lawrence (2) The CQC should confirm that it is now satisfied that the Trust has addressed the training of current staff and has in place appropriate measures to ensure ongoing training for new staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 1st January 2024. 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 [redacted], parents of the deceased,North Bristol NHS Trust, and the Care Quality Commission. I shall send a copy of your response to [redacted] and North Bristol NHS Trust I have sent a copy of my report to the Chief Coroner. 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	**6th November 2023** P. Harrowing **Area Coroner**