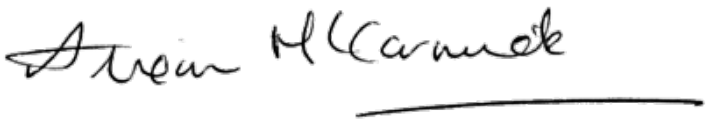
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Royal Berkshire Hospital** **2 Berkshire and Surrey Pathology Services**
1	**CORONER** I am Alison MCCORMICK, Assistant Coroner, Berkshire for the coroner area of Berkshire
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 18 November 2022 I commenced an investigation into the death of Michael James NYE aged 48. The investigation concluded at the end of the inquest on 07 February 2024. The conclusion of the inquest was that: On advice from his General Practitioner Mr Nye attended the Emergency Department of the Royal Berkshire Hospital at 18.33 on 14th November 2022 suffering from sepsis due to a Streptococcus A skin and soft tissue infection. A single working diagnosis of an upper arm DVT was made by the Emergency Department consultant on call. The Emergency Department was exceptionally busy that night and there were delays in obtaining blood test results, CT scans, escalating Mr Nye's case to the Intensive Care Unit team and prescribing antibiotics or any other treatment to target sepsis from skin and soft tissue infection. Mr Nye's condition was observed to deteriorate at about 23.45 and he went into cardiac arrest at about 01.20am on 15th November 2022. A return of spontaneous circulation was achieved after about 3 minutes, but after a CT scan at about 03.00 Mr Nye suffered a further cardiac arrest and resuscitation attempts were unsuccessful. His death was verified at 04.05 on 15th November 2022. On the balance of probability Mr Nye's death was more than minimally contributed to by: (i) over-crowding in the Emergency Department, lack of a resus bed and pressure on clinical resources; (ii) delay in considering a differential diagnosis of sepsis from skin and soft tissue infection; (iii) delay in obtaining blood test results; (iv) delay in organising and undertaking CT scanning; (v) delay in prescribing antibiotics to target sepsis from skin and soft tissue infection; (vi) delay in escalating his case to the Intensive Care Team.
4	**CIRCUMSTANCES OF THE DEATH** On advice from his General Practitioner Mr Nye attended the Emergency Department of the Royal Berkshire Hospital at 18.33 on 14th November 2022 suffering from sepsis due to a Streptococcus A skin and soft tissue infection. A single working diagnosis of an upper arm DVT was made by the Emergency Department consultant on call. The Emergency Department was exceptionally busy that night and there were delays in obtaining blood test results, CT scans, escalating Mr Nye's case to the Intensive Care Unit team and prescribing antibiotics or any other treatment to target sepsis from skin and soft tissue infection. Mr Nye's condition was observed to deteriorate at about 23.45 and he went into cardiac arrest at about 01.20am on 15th November 2022. A return of spontaneous circulation was

	achieved after about 3 minutes, but after a CT scan at about 03.00 Mr Nye suffered a further cardiac arrest and resuscitation attempts were unsuccessful. His death was verified at 04.05 on 15th November 2022.
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) a. Delays in blood tests being completed at night at the Royal Berkshire Hospital, and notification to clinicians on the Electronic Patient Record of abnormal results which are being reviewed.; b. The burdensome and time consuming out of hours system for clinicians requesting CT scans from an external provider; c. The lack of contemporaneous record keeping in the Emergency Department; d. The lack of a specific night time Internal Escalation Policy. A number of the general Internal Escalation Policy measures are not effective at night; e. The need for training of **all** Intensive Care Unit clinicians at **all** levels, both existing Intensive Care Unit clinicians and new joiners, in the policy that a "just to let you know" call should result in an Intensive Care review of the patient; f. The need for training and education of **all** clinicians on atypical presentation of sepsis and the need for a high index of suspicion for sepsis, particularly in the presence of a high lactate.
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 April 09, 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 the Chief Coroner and to the following Interested Persons Michael Nye's family I have also sent it to 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: 13/02/2024**  **Alison MCCORMICK** **Assistant Coroner, Berkshire for Berkshire**