The Princess Alexandra Hospital
NHS Trust

Hamstel Road
Harlow
Essex
CM20 1QX

Private and Confidential

Area Coroner Sonia Hayes
Essex Coroner's Court
Chelmsford County Hall
Victoria Road
Chelmsford
CM1 1QH

7th May 2024

Dear Coroner Hayes,

I write in the matter of the late Ernest Smith in response to your recent Regulation 28 Report to prevent future deaths.

Mr Smith was admitted to Princess Alexandra Hospital on 22nd February 2023 following a fall. He tested positive for Covid-19 and was transferred to Kingsmoor ward whilst waiting for a care package before he could be discharged. He was asymptomatic on the ward until 11th March when he developed a painful swelling on his left calf. This was scanned and increased in size and noted to be a haematoma. His VTE prophylaxis (Heparin) was stopped and on 13th March he had an evacuation procedure undertaken by the Orthopaedic team. On 15th March he was discharged to St Margaret's Hospital for rehabilitation.

Mr Smith was readmitted to Princess Alexandra Hospital on 24th March where he was cared for on Winter ward. His case was discussed by the Orthopaedic team and in accordance with established protocol, advice regarding his haematoma was requested from the plastic surgery team at Broomfield Hospital. The advice from Broomfield was received on 4th April whereupon a wash out and debridement of his haematoma took place on 5th April. Unfortunately despite on-going care, Mr Smith deteriorated and sadly passed away on 10th April 2023.

I note that the areas of concern which you have raised appear to relate to three distinct points. To address these points, we have developed a number of actions. Whilst some are still ongoing, I am confident that the Trust is on course to deliver the necessary changes to ensure that there are no further risks of severe harm or deaths from the points you have raised.

Points a b & c- A delay in conducting a medical review

We agree that there was a delay in conducting a medical review for Mr Smith from Friday 10th until Sunday 12th March. Since Mr Smith's admission, the doctors on call now have an additional formal 'tasks' list using an established software tool called Nervecentre. All

outstanding 'tasks' relating to patients are now articulated between day and night teams during the clinical handover of patients using this list. Coordination for the care of patients out of hours is the responsibility of a dedicated Hospital at Night team.

Point d & e – A delay in the administration of antibiotics from Thursday 30th March until Monday 3rd April.

We agree that there was a delay in commencing intravenous antibiotics. However, Mr Smith was prescribed a broad spectrum oral antibiotic (Doxycycline) which would have been appropriate for his haematoma, given his allergy to Penicillin. Despite him having declined the first dose on 25th March, it was then administered 100mgs daily from 26th March.

Point f- A failure to reinforce the Sepsis 6 protocol.

We agree that we did not implement 'Sepsis 6' formally in Mr Smith's case. Since his episode of care, we have taken steps to improve the management of Sepsis at the Trust. We have been successful in recruitment into a Sepsis Lead Nurse position. This role includes ensuring Trust-wide compliance with the Sepsis 6 protocol. She is currently working towards ensuring 100% compliance to Sepsis training in all of our clinical areas, and the inclusion of Sepsis training as part of our mandatory training programme for all clinical staff, to be extended in due course to non-clinical staff.

We have also implemented a Sepsis awareness programme, part of which included a Sepsis Awareness Day on 21st March 2024 which was well very attended by staff. We remain committed to cyclical audits and improvement programmes relating to Sepsis.

I hope this letter helps address the concerns raised in your Regulation 28 notice for prevention of future deaths.

Please do not hesitate to contact me if you require any further details.

Yours sincerely

[redacted]

[redacted]
Medical Director