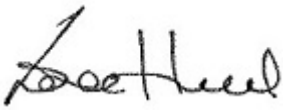
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of state for Health** **2. University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Louise Hunt, Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under 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 9 November 2023 I commenced an investigation into the death of Tracey Ann FARNDON. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Natural causes contributed to by a delay in diagnosis and treatment of sepsis. Her death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** **Tracey was admitted to the emergency department at the Queen Elizabeth Hospital at 02.17 on 25/04/23 with a 3 day history of diarrhoea and vomiting and severe lower back pain radiating down the buttock and right leg. Initial assessment was undertaken however her blood pressure could not be recorded due to it being very low and no NEWS2 score was calculated. It was not appreciated that Tracey likely had sepsis and no sepsis screen or treatment was given. Tracey was provided with pain relief but no further assessment or observations were undertaken until 07.20 when she was found to have a low blood pressure and a NEWS2 score of 6. She was moved to majors after 08.00 when she was noted to be very unwell. She was not reviewed by a doctor until 08.30 who suspected she was suffering from dehydration due to the diarrhoea and vomiting and fluids were administered but no sepsis screen was undertaken and no sepsis treatment was provided. She deteriorated rapidly with blood gases showing a severe metabolic acidosis. She went into cardiac arrest at 10.30 and sadly could not be saved. Post mortem showed evidence of severe pneumonia and a septic spleen. On balance she was likely suffering from severe sepsis when she was admitted to hospital and there were delays in diagnosing and treating this condition. The emergency department was overwhelmed with patients at the time of Tracey's presentation which impacted on the care provided to her.** Following a post mortem the medical cause of death was determined to be: **1a Septic shock** **1b Sepsis secondary to community acquired pneumonia**

	1c **II**
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. The inquest heard how the emergency department was, and continues to be, overwhelmed with patients with insufficient staff to care for, monitor and manage those patients. There is continued regular use of agency staff. This directly impacts patients' safety and is a risk of future deaths. 2. The inquest heard how staff failed to consider a diagnosis of sepsis throughout Ms Farndon's admission. There is a concern that staff do not fully understand the variable signs and symptoms of sepsis and there is a risk of future deaths. 3. Ms Farndon's BP was not recordable when she first presented at the emergency department. It was likely to be very low. This was not considered by the staff concerned and no further attempts were made to assess Ms Farndon's BP. There is a concern staff do not understand the implication of a low BP, the importance of continued observations when a key parameter cannot be recorded and that this may indicate the patient is seriously unwell. This raises a concern of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 31 May 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: Ms Farndon's family I have also sent it to the Medical Examiner, ICS, NHS England, CQC, who may find it useful or of interest. 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	**5 April 2024** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**