REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Tameside General Hospital 2) Secretary of State for Health and Social Care
1	CORONER I am Alison Mutch, Senior Coroner for the coroner area of South Manchester
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 17th April 2023, I commenced an investigation into the death of Jordan George James Fogg HOWARTH. The investigation concluded on the 20th March 2024 and the conclusion was one of Narrative: **Died from the complications of a severe inflammatory response contributed to by neglect. The medical cause of death was 1a) Multi-Organ Failure on the background of a severe inflammatory response of unknown aetiology.**
4	CIRCUMSTANCES OF THE DEATH Jordan George James Fogg Howarth was a fit, healthy 25-year-old. He was admitted to Tameside General Hospital on 3rd April 2023 when he was unwell and deteriorating. The cause of his deteriorating condition was unclear. Tests found no surgical cause and no evidence of infection. It was suspected that there may be an auto immune reaction. There was no co-ordinated approach between specialists to identify the cause of his deterioration. There was no continuity of his care. On the evening of the 4th April he should have been escalated for a further critical care review under the Trust policy. It did not happen. He was moved to another ward. It was not recognised that he had triggered for a critical care review and that one had not been requested. On the morning of 5th April 2023, his condition was clearly deteriorating. A critical care outreach review at about 12:35 identified he needed to be admitted to ICU and a review be undertaken by an ICU consultant because all of his observations

	were consistent with his body shutting down and going into shock. His condition was escalated to the ICU consultant who decided not to review him and not to admit him to ICU despite his declining clinical picture. He should have been reviewed and admitted to ICU at that point. He was not admitted until five hours later when his condition had deteriorated even further. Earlier admission to ICU would have prevented such a rapid deterioration and allowed for earlier support to have been provided to his organs. Following admission to ICU his symptoms were consistent with his organs failing and requiring full support. He had a cardiac arrest at about 3:30am on 6th April 2023 and could not be resuscitated. On the balance of probabilities had he been reviewed and admitted to ICU following the first review by the critical care outreach team on 5th April he would not have died when he did.
5	<u>CORONER'S CONCERNS</u> During 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 evidence that whilst there was input into Jordan's care from both the microbiologist and the consultant physician there was not a joint approach to his care and no detailed discussions regarding the decision to withhold antibiotics. The inquest was told that this decision was reached by the microbiology team and as a consequence, antibiotics were withheld without further alternative treatments being put in place despite how unwell he was and despite the fact that the treating clinicians were unclear about the cause of his deterioration. 2. In relation to ICU the evidence before the inquest was that the Critical Care Outreach Practitioner had identified that Jordan needed to be moved to ICU urgently. This view had then to be ratified by the ICU Consultant if he was to be accepted into ICU. There was no documentation from the ICU consultant setting out their rationale for not examining Jordan at that point and for declining to admit him at that point. All the documentation was in the Critical Care Practitioner's notes. There was no evidence of any discussions between the medical consultant and the ICU consultant about the decision in the clinical notes. 3. The trust policy was that anyone who had a NEWS2 score of 5 and no ceiling of care should be referred to the CC Outreach team. The inquest

	heard evidence that this was not followed on a number of occasions and the fact it had been missed was not identified by more senior members of the nursing team. 4. The inquest heard oral evidence of conversations that it was told had taken place between consultants in a number of specialisms about Jordan. These were not documented in his notes. 5. The inquest heard that despite the complexity of his case there was no evidence of a multi-disciplinary discussion/approach to assess his position fully and that it was unclear who was responsible for the continuity of his care.
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 26th June 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 namely [redacted] on behalf of the family, 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	**Alison Mutch** **HM Senior Coroner**  **01/05/2024**