**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO: 1) NHS England 2) Greater Manchester Integrated Care |
| 1 | CORONER<br><br>I am Alison Mutch Senior Coroner, for the coroner area of South Manchester |
| 2 | CORONER'S LEGAL POWERS<br><br>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<br><br>On 1st August 2023 I commenced an investigation into the death of Michael Clarke. The investigation concluded on the 28th March 2024 and the conclusion was one of Narrative: **Died from the complications of urosepsis following a previous medical procedure, contributed to by his underlying health conditions. The medical cause of death was 1a) Multiple organ failure 1b) Urosepsis on the background of a cystoscopy on 26/07/23 II) Diabetes mellitus, end stage kidney disease, atrial fibrillation, hypertension.** |
| 4 | CIRCUMSTANCES OF THE DEATH<br><br>Michael Clarke had a complex medical history that included diabetes, end stage renal failure, hypertension, and atrial fibrillation. He required dialysis three times a week. On 20th July 2023 Michael Clarke saw his GP for a suspected urinary tract infection and reported blood in his urine. He was prescribed antibiotics for the suspected infection and referred on the 2 week pathway for investigation of the cause of the bleeding. On 26th July 2023 he was seen in the cystoscopy clinic under the 2 week wait referral pathway. The urine culture from the sample on 21st July showed mixed growth. The cystoscopy found no evidence of cancer although there was evidence of significant bladder debris that was cleared out. On 28th July 2023 Michael Clarke felt very unwell. At 21:20 a |

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| | call was placed to Northwest Ambulance Service by the out of hours nurse indicating they were concerned he had sepsis and an ambulance was required. The call was categorised as a category 3 which meant an ambulance should have been dispatched in 1 hour. Due to demand the wait was in excess of 4 hours. The nurse indicated 1 hour was an acceptable time frame. After 1 hour no ambulance attended and a further call was made. The category remained at 3. At 23:38 a further call was made and the call was categorised as a category 2 call. An ambulance arrived and took him to hospital. At Tameside General Hospital he was diagnosed with suspected urosepsis probably triggered by the cystoscopy. He was started on intravenous antibiotics and was moved to the Intensive Care Unit for full organ support. He continued to deteriorate and died at Tameside General Hospital on 30th July 2023. |
| 5 | <u>CORONER'S CONCERNS</u><br><br>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.<br><br>The MATTERS OF CONCERN are as follows. –<br>1. The inquest was told that due to significant demand the wait time for an ambulance in category 3 was in excess of 4 hours rather than the target 1 hour. The inquest was told that this was not unusual and was still an ongoing issue. The evidence was that this was not unique to NWAS but the general picture in England. The inquest was told that there had been improvements in category 1 and 2 response times but to achieve this category 3 calls continued to have these significant delays.<br>2. The inquest was told that the initial call to NWAS was made by the out of hours nurse. She made it clear that she felt the ambulance response needed to be within 1 hour. As this was in theory the response time consistent with a category 3 response, she accepted the categorisation. This acceptance did not appear to take into account that on that evening a category 3 call was not going to result in an ambulance within 1 hour.<br>3. The evidence before the inquest was that there were no specific sepsis trigger questions on the ambulance pathway. The nurse suspected sepsis and gave that indication but that did not trigger a faster response despite the recognition that where sepsis is suspected antibiotics need to commence as a priority. |

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| 6 | ACTION SHOULD BE TAKEN<br><br>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<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th June 2024. I, the coroner, may extend the period.<br><br>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<br><br>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, Tameside General Hospital who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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**<br>**HM Senior Coroner**<br><br>  <br><br>**03/05/2024** |