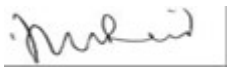
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) [redacted] Chief Executive, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester WR5 1DD; 2) [redacted], National Medical Director, NHS England;
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 28 July 2023 I commenced an investigation and opened an inquest into the death of Michael Leslie PEGG. The investigation concluded at the end of the inquest on 23 January 2024 The conclusion of the inquest was that Mr. Pegg *"died from natural causes."*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mr. Pegg come by his death?", I recorded as follows: *"On 13.1.23 Michael Pegg, who lived with congenital adrenal insufficiency and epilepsy, was admitted to Worcestershire Royal Hospital after suffering two significant seizures at home earlier that morning. Early the following morning he suffered a significant deterioration in his condition and developed pneumonia. Despite treatment, he continued to decline and died in hospital on 15.1.23."*
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) Over the two days that Mr. Pegg was at Worcestershire Royal Hospital, those treating him failed to apply the NICE guidelines which relate to the treatment of those with adrenal insufficiency conditions who are being treated for intercurrent illness. [redacted], who conducted the Trust's serious incident investigation into these events, told the inquest: *"There was a policy in place for administering steroids, as per the 2020 NICE guidelines – this advises:* *(a) double dosing of oral steroids in cases of intercurrent illness until 48 hours after recovery (also known as Sick Day rule 1);* *(b) if [the patient has] significant trauma, prolonged vomiting or diarrhoea, then 100mg IV hydrocortisone [should be administered];*

	(c) if suspected adrenal crisis, 100mg IV hydrocortisone immediately." In fact, the steroid treatment provided to Mr. Pegg during this admission fell far short of those Guidelines, in that: (a) He only received one double dose of his oral hydrocortisone medication, which he was usually required to take twice a day; (b) He received no doses at all (double or standard) of his oral prednisolone medication, which he was usually required to take once a day; (c) Although he did eventually receive a 100mg dose of IV hydrocortisone on 14.1.23, this should have been given much earlier that day when his condition seriously deteriorated. 2) Although in this case, I was unable to conclude that the above omissions in steroid treatment probably caused or contributed to Mr. Pegg's death, it was nonetheless concerning to hear that none of those treating him had sufficient awareness of the NICE Guidelines as to be able to apply them properly in his case. Unless action is taken to ensure clinicians employed by the Trust are aware of, and able to apply these Guidelines, there remains a risk that another patient with adrenal insufficiency may die in similar circumstances; 3) For a substantial part of his time at Worcestershire Royal Hospital, Mr. Pegg was being treated in a bed in a corridor in the Emergency Department, and then in the Majors Overflow area, both busy, crowded and noisy areas ill-suited to the proper treatment of patients. In his evidence to the inquest about trying to ensure that the Trust's staff are aware of these Guidelines, Dr. Raven told the inquest: *"As long as we still have crowded settings, it is difficult to provide assurances that these guidelines will be followed, for example because we have a high turnover of locum clinicians and agency nursing staff."* It is particularly concerning to hear that patients' wellbeing may be put at risk because a hospital Trust may not be able properly to ensure that the staff it employs are aware of, and able to apply NICE Guidelines. It is perhaps unfair to put responsibility for rectifying this situation solely at the door of the Worcestershire Acute Hospitals NHS Trust, which is why this report is also being sent to NHS England and Health Education England.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of Worcestershire Acute Hospitals NHS Trust, and the National Medical Director of NHS England, 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 **22 March 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: (a) [redacted], Mr. Pegg's widow. 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	**26 January 2024**  **David REID** **HM Senior Coroner for Worcestershire**