	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive,** **Blackpool Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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** The death of Sandra Phillpott on 31st October 2023 was reported to me and I opened an investigation, which concluded by way of an inquest on 5th July 2024. I determined that the medical cause of Sandra's death was: **1a Multi - organ failure** **1b Sepsis with Disseminated Vascular Coagulation [D.I.C]** **1c Streptococcus Pneumoniae** **II E.coli 0157 infection; left ventricular hypertrophy; coronary artery atheroma** In box 3 of the Record of Inquest I recorded as follows: **Sandra Phillpott was aged 57 years. She was regarded as active and previously healthy. At around 5pm on Friday, 27th October 2023 she returned home after a holiday in Egypt with her twin Sister. By the time she arrived home she was experiencing some cold-like symptoms due to a bacterial infection - later identified as E.coli 0157 - contracted whilst in Egypt from an unidentified source. The situation was complicated after she then developed a pneumococcal infection which left her feeling cold and shivering. Over the course of that weekend, Sandra remained unwell but did not deteriorate noticeably until the morning of Monday 30th October 2023. She had largely preferred not to seek medical attention, expecting her symptoms to improve. After her condition became more concerning she attended a walk - in - centre from where she was appropriately transferred to the hospital emergency department. She had to remain in an ambulance for around forty minutes before she could enter the department. Initial investigations suggested she had a suspected pulmonary embolism, but she was also showing signs of infection and by 12 noon antibiotics and intravenous fluids had been prescribed. These were not administered in a timely fashion. Her presentation had not indicated she had a specific pneumococcal infection until later that afternoon when following a delayed transfer to the intensive treatment unit a consultant noted a florid rash indicative of pneumococcal sepsis. The**

	results of blood tests would later confirm the infection to be Streptoccocus Pneumonaie. Over subsequent hours, Sandra's condition deteriorated and her death confirmed at 05.50 hours on 31st October 2023. The likelihood Sandra had sepsis had been under appreciated, and there was a missed opportunity to provide timely antibiotic therapy and fluids, but from the available evidence this would not have altered the fatal outcome because from around the time antibiotics were prescribed, Sandra's condition was non - survivable. She died from complications arising from a pneumococcal infection. She had been more susceptible to dying from such infection due to the effects of heart disease identified at post mortem examination, and reduced physiological reserves caused by the separate infection which had been contracted in Egypt. In box 4 of the Record of Inquest I determined that: **Natural causes.**
4	**CIRCUMSTANCES OF THE DEATH** In addition to the contents of section 3 above, the following is of note: **As mentioned above, despite showing signs of infection, the necessary treatment was not provided in a timely manner, notably antibiotic therapy and the administration of intravenous fluids.** **Sandra's shortness of breath, some reported calf pain, and recent flights contributed to a feeling amongst some of the clinical / nursing staff that she had a likely pulmonary embolism [later ruled out] and this in part contributed to a lack of focus on the possibility she had developed a potentially fatal infection.** **A helpful Patient Safety Incident Investigation [PSII] Report, provided to the court in advance of the inquest by Blackpool Teaching Hospitals NHS Foundation Trust, found that:** • **There had been delays in sepsis management** • **The initial treatment had focused upon ruling out a pulmonary embolism and deep vein thrombosis, delaying sepsis management.** • **Sandra had multiple sepsis triggers, but the main focus remain a pulmonary embolism.** Having considered all of the above, I have determined that I have a duty to write this report.
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 could occur unless action is taken. In the circumstances it is my statutory duty to send the report: The **MATTER OF CONCERN** is as follows. – • **The concern I raise relates to the recognition of suspected sepsis, and the need for timely provision of treatment for suspected sepsis.** • **Notwithstanding that I determined that from the available evidence timely treatment would not have altered the fatal outcome, I remain firmly of the view this report is necessary.**

	• **I was informed at the inquest that there have been significant improvements in the management of sepsis within the Emergency Department.** • **This court has raised concerns with the hospital Trust about this issue previously, and I know it is an issue which the Trust is very aware of and I do not doubt that efforts have been made to make improvements, but having conducted this inquest into Sandra's death, in my view there remains a risk that sepsis will go unrecognized, and urgent treatment will be delayed, putting patients attending Blackpool Victoria Hospital at risk. My duty to write this report is therefore met. It is not for me to be prescriptive about what action ought to be taken, but to raise this concern should I feel this is necessary.**
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. Given the approaching holiday period I have extended this period to Friday 13th September 2**024**. I, the coroner, may extend the period further. 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: • The family of Sandra Phillpott. 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	12/07/24 Signature____  _____ Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**