# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**1 North East Ambulance Service NHS Foundation Trust.**<br>**2 NHS England.**<br>**3 Association of Ambulance Chief Executives.**<br>**4 Royal College of General Practitioners.** |
| **1** | **CORONER**<br><br>I am Paul APPLETON, Assistant Coroner for the coroner area of Teesside and Hartlepool Coroner's Service |
| **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 16 December 2022 I commenced an investigation into the death of Margaret HUNTLEY, aged 63. The investigation concluded at the end of the inquest on 9 August 2024.<br><br>The medical cause of death was recorded as:<br>1a) Multi-Organ Failure<br>1b) Dehydration; Lack of exogenous steroids; Covid-19 infection.<br><br>The Conclusion of the inquest was a narrative conclusion as follows:<br><br>Margaret Huntley died as a result of multi-organ failure which was caused by dehydration, lack of exogenous steroids, and Covid-19 infection. Margaret's death was contributed to by delays in identifying that she required exogenous steroid medication, and delays in the prescription and administration of that exogenous steroid medication. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Margaret Huntley died on 10 December 2022 at the University Hospital of North Tees, Hardwick Road, Stockton on Tees.<br><br>Margaret was prescribed and dependent on exogenous steroid medication, hydrocortisone, following a previous hypophysectomy procedure due to a benign non-functioning pituitary adenoma. Following a period of illness primarily diarrhoea, nausea and vomiting, Margaret was seen at an urgent care centre on 3 December 2022 and prescribed anti-emetic medication. |

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| | On 5 December 2022, Margaret called 999 and requested an Ambulance; during this telephone call, Margaret stated that she took hydrocortisone. Margaret was reviewed by a Paramedic on 5 December 2022 and again on 7 December 2022 with the treatment pathway being for GP review. Margaret's prescribed medications were not ascertained or recorded by the attending Paramedic on those dates and the attending Paramedic was not aware that Margaret was prescribed exogenous steroid medication.<br><br>On 8 December 2022, in the presence of attending Paramedics, Margaret lost consciousness and she was transported to the University Hospital of North Tees. Margaret's prescribed medications were recorded during this Paramedic attendance; however, the recorded medications did not include, and the attending Paramedics were not aware of, the prescribed exogenous steroid medication, hydrocortisone. Margaret was admitted to the Emergency Department of the University Hospital of North Tees at 17:37 on 8 December 2022 and was transferred to the Emergency Assessment Unit at 05:09 on 9 December 2022.<br><br>At 05:41 on 9 December 2022, Margaret was prescribed 10mg oral hydrocortisone which was administered to her at 09:09. At 10:00 on 9 December 2022, Margaret clinically deteriorated, and she received treatment which included 100mg of intravenous hydrocortisone medication for suspected Addison's Crisis. Margaret was transferred to the critical care unit and diagnosed to have Disseminated Intravascular Coagulation. Despite treatment, Margaret deteriorated and sadly died on 10 December 2022.<br><br>Margaret died as a result of multi-organ failure which was caused by dehydration, lack of exogenous steroids, and covid-19 infection. Margaret's death was contributed to by delays in identifying that she required exogenous steroid medication, and delays in the prescription and administration of exogenous steroid medication. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the |

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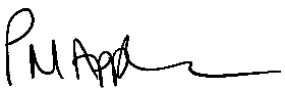
| | circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>1. There is a lack of understanding amongst (non-clinical and clinical) Ambulance Service staff as to the importance of steroid medication and the steps to be taken should a patient (a) report that they are prescribed steroid medication and/or (b) present with symptoms potentially consistent with steroid insufficiency/Addison's Crisis.<br><br>2. There is not, within the NHS Pathways system or otherwise, guidance or processes for Ambulance Service staff triaging calls, including non-clinically qualified staff, to follow regarding (a) the importance of steroid medication and the need to establish, if a patient raises during a call that they are prescribed steroid medication, detailed information regarding that prescription to include the type of prescription and the reasons for it; (b) actions to be taken or processes to follow should a patient raise during a call that they are prescribed steroid medication.<br><br>3. It is unclear as to whether Margaret Huntley had been issued with a Steroid Emergency Card and/or information around use of such a Card. I am concerned that there needs to be improved usage, and awareness, of Steroid Emergency Cards.<br><br>4. It was confirmed in evidence that it is possible for GPs to request that an alert is placed on to the Ambulance Service's system(s) to alert Ambulance Service staff to specific patient health conditions, such as steroid insufficiency. I am concerned that (a) there is inadequate awareness of this ability amongst GP's; (b) this action is not routinely being taken by GPs. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisations) 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 08 October 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:<br><br>1. Family of Margaret Huntley.<br>2. North Tees and Hartlepool NHS Foundation Trust<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** | **Dated: 13/08/2024** |



**Paul APPLETON**
**Assistant Coroner for**
**Teesside and Hartlepool Coroner's Service**