M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

21st September 2018 REF: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Southmead Hospital**
1	**CORONER** I am Terence Moore Assistant Coroner for **Area of Avon**
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 18/07/2018 00:00:00 I commenced an investigation into the death of Annette HILL. The investigation concluded at the end of the inquest 20th September 2018. The conclusion of the inquest was The deceased was transported to the emergency department with increasing breathlessness. She was appropriately assessed under the trusts sepis protocol and given antibiotics before a chest x-ray could be taken. She suffered an unexpected reaction and died despite advanced CPR.
4	**CIRCUMSTANCES OF THE DEATH** Presented to the emergency department with COPD, collapsed following a dose of IV amoxillin
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) This patient received IV antibiotics correctly in accordance with the Sepsis 6 guidelines. However, she did not in fact require antibiotics on an overview of the available information. There appears to be an unresolved tension between the Sepsis 6 guidelines and the BTS COPD care bundle for the management of patients with advanced respiratory disease. (2) (3)

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Southmead Hospital 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 Friday 02nd November 2018. 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 [NAMES] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] 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	21/09/2018 Signature Terence Moore Assistant Coroner **Area of Avon**

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