REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF MICHAEL RAMON JERVIS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**. Chief Executive, Royal Cornwall Hospital Trust**
1	**CORONER** **I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.**
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 21 July 2024 I commenced an investigation into the death of 69-year-old Michael Ramon Jervis. The investigation concluded at the end of the inquest on 24 October 2024. The medical cause of death was found to be *1a Neutropenic Sepsis* *1b Chemotherapy* *II Germ Cell Testicular Cancer* The four questions - who, when, where and how – were answered as follows …

	Michael Ramon JERVIS died on 16 July 2023 at Royal Cornwall Hospital Truro from Neutropenic Sepsis, a recognized complication of chemotherapy treatment for Testicular Cancer. There was a 20-hour delay in the administration of antibiotics from the point at which clinical observations repeatedly indicated that antibiotics were clearly required. This delay in the administration of antibiotics more than minimally contributed to his death. The conclusion as to the death is … *Michael Ramon JERVIS died from a recognized complication of necessary medical treatment contributed to by neglect.*
4	**CIRCUMSTANCES OF THE DEATH** 1. Mike was diagnosed with testicular cancer in May 2023 at Royal Cornwall Hospital Truro (RCHT). The cancer was treatable. The treatment plan was four cycles of chemotherapy. The aim of treatment was curative. Prior to the cancer diagnosis Mike was an independent, fit, and active man. 2. Mike underwent three cycles of chemotherapy. The cancer responded well to chemotherapy with the tumour markers falling from 18,000 to 18 by 5 July 2023. 3. Mike was discharged home on 9 July 2023 with a plan to admit him for the fourth round of chemotherapy. 4. However, Mike was re-admitted on 13 July 2023 to RCHT after becoming unwell. Bloods were taken on admission which revealed neutropenia. This is a condition which involves a significant weakening of the immune system and indicated a high risk of sepsis. 5. At 1600 hours 13 July 2023, an acute oncology nurse specialist recorded on Mike's notes that antibiotics should be administered should Mike's temperature fall below 36 or rise above 37.5. This note is consistent with hospital policy and guidance. 6. The court found that infections and sepsis are a recognized complication of chemotherapy because the treatment leaves patients immuno-compromised. 7. The court heard that a bundle of six measures are required when clinical indicators of sepsis are present, known as the 'Sepsis Six' bundle. The indicators for implementation of sepsis six, particularly for those immuno-compromised, include temperature above 37.5, below 36. 8. The six measures include administering fluids and administering antibiotics. The court found that of the six measures, antibiotics is the most important and should be administered within 60 minutes. 9. The court heard that the Sepsis Six bundle has been policy since 2006 at RCHT and nursing staff and doctors are expected to be aware of and implement sepsis six when indicated. 10. The first indication that sepsis six should be implemented was at 1710 hours on 13 July 2023 when observations gave a NEWS score of 4 in

	which low temperature (temp 35.6) and low blood pressure (78/42) should have resulted in a medical review and met the low threshold for IV antibiotics. 11. Thereafter numerous observations were taken over the following hours indicating that Mike met the low threshold for IV antibiotics. 12. In total, there was a 20-hour delay in the administration of antibiotics from 1710 hours on 13 July 2023 until 14:30 hours the following day. 13. The court found that this delay in the administration of antibiotics more than minimally contributed to his death and amounted to neglect.
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) Repeated observations and NEWS scores were taken by numerous staff members which indicated that sepsis six should be triggered and that antibiotics were required but this did not happen. (2) There was an absence of a digital alert on hospital software, which could have alerted staff to the need to implement sepsis six.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 26 February 2025. 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 family. 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	**30 December 2024**	**Guy Davies**