Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Royal Stoke University Hospital** **2 NHS England**
1	**CORONER** I am Daniel HOWE, H M Area Coroner for the coroner area of Staffordshire and Stoke-on-Trent
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.
3	**INVESTIGATION and INQUEST** On 05 April 2024 I commenced an investigation into the death of Philip John UNWIN aged 68. The investigation concluded at the end of the inquest on 18 February 2025. The conclusion of the inquest was that: Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** Mr Unwin was a 68 years old gentleman who was admitted to Royal Stoke University hospital on 2 April 2024 at 00:45 due to fever, shortness of breath and chest pain. He was commenced on broad spectrum antibiotics within an hour of his arrival for suspected sepsis due to Urinary Tract Infection although it was subsequently confirmed that sepsis was secondary to pneumonia. He remained in the resus area of the Emergency Department despite a progressive deterioration in his condition and escalations from the nursing team to the medical team for him to be reviewed. Transfer to ICU was not initiated until approximately 14:30 at which time he was noted to be acutely unwell and in peri arrest. After being transferred to ICU at approximately 16:00 supportive intervention including sedation, ventilation and vasopresser medication failed to reverse his condition and he passed away in hospital on 3 April 2024 due to multi organ failure secondary to pneumonia.
5	**CORONER'S CONCERNS** 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 circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Although the conclusion of the inquest was one of Natural Causes there was evidence of a failure for medical teams to respond to concerns that the patient was deteriorating whilst awaiting assessment in the resuscitation area of the Emergency Department of Royal Stoke University Hospital. It was accepted by witnesses from the hospital that the patient should not have deteriorated to a 'moribund' state within that area of the hospital when concerns

	had been raised by staff and family, and that review and escalation to intensive care should have been initiated sooner (albeit the evidence was that this did not more than minimally contribute to the death). As a result of the concerns raise by hospital staff regarding missed opportunities to escalate care in a timely manner the hospital undertook a Patent Safety Incident Investigation (PSII). As a result of that investigations a number of recommendations were made with assurances given to the report author that work is being undertaken to review and amend policies and procedures focused on reviewing, escalating and referring deteriorating patients. However, the inquest was told that although the Emergency Department Resuscitation area was where the illest patients were placed awaiting review, staffing levels were not in compliance with national guidance. The Royal College of Emergency Medicine (RCEM) "Nursing Workforce Standards for Type 1 Emergency Departments" (Appendix 5) states "There will be a minimum of Registered Nurse to each patient in the resuscitation area". The recommendation continued that there should be a named nurse allocated to each patient which should be 1:1 as per National Guidance. The concern is that the current model of staffing within the Emergency Department Resus area is not in compliance with national guidance and the recommendations following internal investigation into the care afforded to the deceased have not been acted upon in this respect.
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 April 16, 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 following Interested Persons [redacted] **Royal Stoke University Hospital** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 19/02/2025**

	 **Daniel HOWE** **H M Area Coroner for** **Staffordshire and Stoke-on-Trent**