University Hospitals of North Midlands NHS Trust

Trust Ref: [redacted]

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14 April 2025

STRICTLY PRIVATE & CONFIDENTIAL
Ms Emma Serrano
Area Coroner
Stoke on Trent and North Staffordshire

Sent via email: [redacted]

Dear Ms Serrano

Christpoher BRADBURY

Further to your letter dated 11 March 2025, I am pleased to provide a response under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013, addressing your concerns surrounding the death of Christopher Bradbury.

Recorded Circumstances of the Death

On the 28 December 2023 Christopher Granville Bradbury fell at his home address and sustained a cut between his two small toes on the right foot.

He was admitted to the Royal Stoke University Hospital, Stoke-on-Trent, on the 2 January 2024. He had symptoms of diarrhoea and vomiting, and it was reported that he had collapsed. He has a lesion on his little toe on his right foot and swelling to his right leg. On examination he was placed on the SEPSIS 6 pathway, and treated in accordance with this. He was examined by an Orthopaedic registrar who ordered an urgent MRI scan, to ascertain the cause of the swelling and the lesion.

On the 4 January 2024, with no MRI scan being done, he received a Consultant review and a diagnosis of Invasive Soft Tissue Infection was made. He was too ill for a MRI scan and was taken directly to theatre for a below the knee amputation.

After the surgery, he did not recover and passed away on the 5 January 2024. There was an opportunity for Mr Bradbury to be given a MRI scan, and if this had taken place, he would have been diagnosed earlier, and received the operative intervention at an earlier stage. It cannot be said that this would have made a difference to the outcome for Mr Bradbury.

It was accepted in evidence that the issue giving rise to the delay in the MRI scan was down to a lack of knowledge of Severe Invasive Soft Tissue Infections, that are not (but are closely related to) necrotising fasciitis. It was accepted in evidence that there is a lack of national Guidelines on this. It was accepted in evidence that the large number of Drs expected to specialise in this, made it almost impossible for them to be taught about this.

[redacted]

The evidence given was that training is being delivered continuously, and the actions from the PSII have been carried out but this is not making significant inroads, it had not been effective at all, and it is thought that this will happen again.

It was accepted in evidence that, when signing medication out, at the hospital, if the medication is not available, no signature is required when choosing option 5 “omitted dose”. This means that there is no audit trail, if a patient is not given their medication, because it is unavailable, or omitted for some other reason.

Concerns

During the course of the inquest, you felt that evidence revealed matters giving rise for concern. In your opinion, matters for concern are as follows.

1. A national lack of knowledge of Severe Invasive Soft Tissue Infections, that are not (but are closely related to) necrotising fasciitis combined with a lack of national Guidelines on this. This being exacerbated by the large number of Drs expected to specialise in this.

2. The evidence given was that training is being delivered continuously, and the actions from the PSII have been carried out but this is not making significant inroads, it had not been effective at all, and it is thought that this will happen again.

3. When signing medication out, at the hospital, if the medication is not available, no signature is required when choosing option 5 “omitted dose”. This means that there is no audit trail, if a patient is not given their medication, because it is unavailable, or omitted for some other reason.

You reported this matter under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

In your opinion, action should be taken to prevent future deaths.

Action Taken

The University Hospitals of North Midlands NHS Trust has taken the issues highlighted during the inquest seriously and indeed, I am grateful that you have raised your concerns to which a response is provided below.

1. We recognise and share the Coroner’s concern regarding the national lack of awareness and guidance relating specifically to Severe Invasive Soft Tissue Infections (SISTIs) that are not necrotising fasciitis, but have similar aggressive and life-threatening characteristics.

   As an individual NHS organisation, we are not directly responsible for developing national clinical guidelines, however, we would fully support any national work to raise awareness of these rare but serious infections, and the development of clear diagnostic and management guidance. We also accept the challenge presented in ensuring wide clinical awareness of rare conditions, particularly in environments where staff rotate frequently, and experience may be limited. This challenge is compounded further by the relative rarity of such presentations, meaning that many clinicians may never have encountered a case during their training or practice. Nevertheless, [redacted] will continue with the important work he is undertaking in this area.

2. Within our Trust, we continue to take the issue of training very seriously. We have already undertaken a significant programme of training and learning following this case, ensuring key themes and learning have been widely shared across our clinical teams.

[redacted]

We are committed to continuing this education, both through formal teaching and case-based discussions. However, again, we do recognise that due to the rarity and complexity of these presentations, training alone will not always ensure early recognition. To that end, we will continue to emphasise the importance of early escalation and senior clinical review where there is any concern about deteriorating soft tissue infections. We believe that early involvement of senior decision-makers, particularly consultants who may have greater experience with rare or atypical presentations, is imperative to supporting early diagnosis and appropriate intervention.

3. With regard to the concern raised about medication omissions and the lack of an auditable trail when a dose is not administered, I can confirm that currently we do not have an Electronic Prescribing and Medicines Administration (EPMA) system in place at our Trust.

   However, the Trust is in the process of implementing EPMA across both our sites. Once implemented, EPMA will provide a robust and transparent record of all medication activity, including when a dose is omitted, the reason for omission and the identity of the person making that decision.
   When we have our EPMA system, the electronic chart will capture everything in one place.

   In the interim, we have developed a Patient Safety Learning Alert requiring staff to document reasons for drug omissions. These omissions are to be documented within the relevant patient record. This alert has been circulated to all staff and is enclosed for your review.

   The implementation of our EPMA will significantly improve the governance and auditability of our medicines management across the Trust and directly addresses the concern raised in the Regulation 28 report.

We do hope that the above information provides assurance that the Trust has taken the concerns raised at the inquest seriously and that both you and Mr Bradbury's family are content with the response that has been provided.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely,

[redacted]

Chief Executive

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