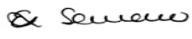
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England; and** **2. Royal Stoke University Hospital.**
1	**CORONER** I am Emma Serrano, Area Coroner, for the coroner area of Staffordshire.
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 the 9 January 2024, I commenced an investigation into the death of Mr Christopher Glanville Bradbury. The investigation concluded at the end of the inquest on 5 March 2025. The conclusion of the inquest was a short form conclusion of complications following a fall. The cause of death was: 1a Severe multi-organ failure 1b Severe septic shock 1c Severe Invasive soft tissue infection 1d Fall II Chronic obstructive pulmonary disease, type 2 diabetes mellitus
4	**CIRCUMSTANCES OF THE DEATH** i) 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. ii) 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. iii) 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. iv) After the surgery, he did not recover an 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. v) 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. vi) 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. vii) 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 train, if a patient is not given their medication, because it is unavailable, or omitted for some other reason.
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. – i) 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. ii) 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. iii) 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 train, if a patient is not given their medication, because it is unavailable, or omitted for some other reason.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 29 April 2025. 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: 1. Family of the deceased. 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	**11 March 2025**  **Miss Emma Serrano** **Area Coroner** **Staffordshire**