REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 9.11.23 , I commenced an investigation into the death of Mrs Marina May Raisbeck The investigation concluded at the end of the inquest on the 16th January 2025 The conclusion of the inquest was a narrative as follows: Marina Raisbeck, known as May, died from sepsis, secondary to a perianal abscess, on 7.11.23 at the Doncaster Royal Infirmary (DRI). Whilst initial treatment was provided for sepsis on admission to Bassetlaw District General Hospital (BDGH) on the evening of 4.11.23, there was a delay in her reaching BDGH on that day, and then there was a further delay in transfer to the DRI for planning of the necessary Incision and Drainage of the abscess. Over the hospital admission period, her kidney function worsened, and the necessary surgery to drain the abscess on 6.11.23, also had an impact on her physiological status. Whilst these issues of delay are serious, it is not possible to say that on balance they have caused or made a more than minimal, negligible or trivial contribution to her death, both because of the extent of her underlying frailty, and the seriousness of the infection that she faced.
4	**CIRCUMSTANCES OF THE DEATH** Marina May Raisbeck, known as May, died on 7.11.23, at the Doncaster Royal Infirmary, Doncaster, South Yorkshire. May was aged 82 at the time of her death. She had a number of significant chronic medical problems, that were being managed, including Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, (with a recent hospital admission), Chronic Kidney Disease, Ischaemic Heart Disease (leading to heart failure), and obstructive sleep apnoea. She also had morbid obesity. There was a RESPECT form in place from July 2023. May also had wound healing difficulties with leg and abdominal wounds managed by the District Nurse team. She was housebound, with an Exercise Tolerance of 5- 10 yards. May developed a red painful lump on her buttock at the end of October 23. She was seen on 1.11.23, and prescribed an antibiotic, Doxycycline. It is unclear whether this was prescribed for a possible chest or water infection. It was an unusual choice for a skin infection/evolving abscess. She was seen again on 3.11.23 and the abscess was clearly noted. It was not painful, but discharging. She was appropriately prescribed

	Flucloxacillin, and a District Nursing team referral made. There were no signs of sepsis on either of these occasions. On the morning of 4.11.23, she was seen by a District Nurse, who provided a dressing. No observations were taken at this appointment but May was not described as systemically unwell. Also on 4.11.23, the family had contacted the Out of Hours (OOH) service, 111, at 09.14 hours, as the 4th was a Saturday. A call back from a clinician from the Bassetlaw OOH GP service occurred at 15.27 hours- it is unclear what happened between the initial call, and the clinician call back, with May's daughter reporting a further call to the 111 service to follow up following the first call. The telephone assessment established that the abscess was now larger (5x5cm reported), and that it was red and painful. There was insufficient exploration of other systemic symptoms of infection, and this assessment should have resulted in a face to face assessment within 2 hours , rather than 6 hours as was arranged. May was then seen by a OOH GP at 19.51 hours on 4.11.23. May was identified as unwell at this point, though with normal temperature, pulse and blood pressure. This appropriately resulted in an ambulance transfer to BDGH, arriving at 21.13 hours. A nurse triage assessment followed at 21.49, where it was recognised May likely had sepsis- she now had a fever, with a low blood pressure of 95/39, a high breathing rate of 25 breaths per minute (though her breathing rate was often high at rest), pulse of 88/minute, just within the normal range. She was given a fluid bolus and IV antibiotics at 22.45, and a diagnosis of an abscess, requiring incision and drainage was made. She was accepted under the surgical team at the DRI (surgery not available at BDGH at the weekend), at 02,00am on 5.11.23. Thereafter, whilst May remained reasonably stable, her fluid balance was not recorded, and there was no repeat blood tests to monitor her lactate, and her kidney function, as should have occurred. She required two fluid boluses to improve her blood pressure, at 11.38 hours and 15.18 hours on 5.11.23 at BDGH. May was finally transferred to DRI on the evening of 5.11.23, and then incision and drainage were appropriately delayed until the morning of 6.11.23, as she was a high anaesthetic risk, and it was appropriate to delay until sufficient daytime staff were available. During surgery, which was completed appropriately, she had a period of 30-40 minutes of low blood pressure, despite treatment. Post operatively she remained drowsy. Over the subsequent 24 hours she developed worsening acute kidney injury. On the evening of 7.11.23 she had a cardiac arrest, and died shortly after. It is possible that earlier incision and drainage, on 5.11.23, would have led to a different outcome for May, but in light of her extensive medical issues leading to significant frailty, and the rapid progression of the perianal abscess leading to sepsis, despite appropriate treatment from the evening of 4.11.23, it is unlikely. There was no discussion between the Emergency Department medical team at BDGH, and the surgical team at the DRI, to consider prioritising May for transfer during 5.11.23, nor any agreed process for easy review of May's clinical parameters to again make an appropriate decision as to any need for more urgent transfer from BDGH to the DRI.
5	**<u>CORONER'S CONCERNS</u>** 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. The lack of a system for prioritisation of urgent surgical patients awaiting transfer to DRI from the Emergency Department at Bassetlaw District General Hospital 2. The lack of a system for monitoring clinical parameters of urgent surgical patients awaiting transfer to DRI from the Emergency Department at Bassetlaw District General Hospital

	I am not reassured that necessary actions to address these serious issues identified are in place.
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 the **15th April 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: 1. The family 2. The Nottingham and Nottinghamshire Integrated Care Board 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	**18th February 2025**  **Dr E. A. Didcock**