MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
EAST LONDON CORONERS, 124 Queens Road, Walthamstow, London E17 8QP
Telephone [redacted] Email [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted], Chief Executive, Barts Health NHS Trust, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB** **Sent via email: [redacted]** **Cc: [redacted]**
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 24 June 2024 I commenced an investigation into the death of Mrs Norma Faye Campbell, aged 59 at the time of her death. The investigation concluded at the end of the inquest on 12 June 2025 with a conclusion of natural causes, contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mrs. Campbell attended the emergency department at Whipps Cross Hospital on the 13 January 2024 at around 12pm. The emergency department was exceptionally busy due to patient acuity and patient numbers. Pressures were added to by the absence of a

	number of locum doctors, due to a pay dispute with the Trust. Mrs. Campbell presented to the emergency department with clear signs of sepsis. Sepsis was recognised very early in her presentation, but the prompt and necessary sepsis care set out in the NICE guidelines was not provided. In particular, Mrs. Campbell required care in the resuscitation area of the emergency department, but there were no resuscitation beds available; there was a delay of around 30 minutes in administering intravenous antibiotics (co-amoxiclav); there was a delay in commencing Amikacin; there was a 2 hour delay in administering clarithromycin following prescription; there was a failure to robustly fluid resuscitate Mrs. Campbell whilst closely monitoring the clinical effect of this; there was no fluid balance analysis; abnormal findings such as the lactate level of 7 were not appropriately monitored and responded to; Mrs. Campbell was not monitored and her care escalated in accordance with the National Early Warning System (NEWS). At around 21.52 on the 13 January 2024 whilst still in the majors area of A&E, Mrs. Campbell suffered a cardiac arrest. Thereafter maximal efforts were made to resuscitate her, but sadly there was no meaningful recovery. She passed away at Whipps Cross Hospital in the early hours of the 14 January 2024. Mrs. Campbell was a 59-year-old lady who had no underlying chronic disease. On the balance of probabilities, had Mrs. Campbell received a NICE guideline compliant and NEWS compliant, level of care, her death would have been avoided
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 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: 1. The inquest heard that the A&E department at Whipps Cross Hospital often has inadequate staffing and medical facilities to address the patient numbers and acuity. The inquest heard that overcrowding in A&E is a national concern. 2. The inquest heard that it is not uncommon to find patients in corridors when they need to be monitored. On the 13 January 2024 there were more than 25 patients in the corridors. They were not receiving an appropriate level of care. 3. There are often insufficient numbers of resuscitation beds. Patients who require a resuscitation area level of care are often directed to the majors area of A&E. The majors area lacks the levels of staffing and lacks the monitoring equipment required to treat this cohort of patients. In the absence of increased numbers of resuscitation beds, a system for continuous monitoring of observations in majors would significantly improve patient care. 4. There is no electronic observation system in place within the A&E department of Whipps Cross Hospital (such as Live Note). Patients presenting with high NEWS scores are not therefore automatically brought to the attention of clinical supervisors. 5. The Critical Care Outreach Team (CCOT) do not currently attend A&E for deteriorating patients. The overcrowding and lack of resourcing in A&E highlights the need for the CCOT to provide support to A&E patients as well as patients on the ward.
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 **4 August 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 am sending a copy of my report to the Chief Coroner, to the family of Mrs Campbell, to the CQC, to the local Director for Public Health and to the Department for Health & Social Care. The Department for Health & Social Care are receiving a copy of this report, as the inquest heard that underfunding of A&E is a concern throughout hospitals nationally. 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 other 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.
9	**16 June 2025**