Royal Cornwall Hospitals
NHS Trust

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Date: 22 July 2025

Private and Confidential
Mr. Guy Davies
Assistant Coroner for Cornwall and the Isles of Scilly
Pydar House
Pydar Street
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Cornwall
TR1 1XU

Dear Mr Davies,

Re: The Late Jason Clemens – Regulation 28 PFD Report and Response

I write in response to the Regulation 28 Report to Prevent Future Deaths, dated and received on the 4 July 2025. This was issued following the inquest into the death of Mr Clemens which concluded on 5 June 2025.

I would like to take this opportunity to express my sincerest condolences to the family of Mr Clemens for their loss.

During the inquest, the evidence revealed matters giving rise to concern. These are as follows:

- A Standard Operating Procedure (SOP) was still outstanding, some 15 months after the death of Mr Clemens
- It was unclear for nursing staff as to what pathway unwell patients on the renal unit should follow
- There is still the absence of a digital alert on hospital software, which could have alerted staff for the need to implement Sepsis Six.

Please find below the response from the Trust and the detail of the actions being taken in relation to the above concern.

Standard Operating Procedure (SOP):

This (SOP) is now completed and has been uploaded onto the Trust's intranet page for all staff to have access to. A copy of the SOP is attached to the response as 'Enclosure 1'.

Clinical Guideline for Unwell Patients on Renal Unit:

A Clinical Guideline has been developed to assist staff on the Renal Unit to regarding the relevant pathway a patient should follow, should they become unwell or deteriorate on the Renal Unit. This has been shared with staff and has been uploaded on the Trust's internal Intranet page for all staff members to review and have access to. A copy of the Clinical Guideline is attached to this response as 'Enclosure 2'.

Digital Alert on hospital system to alert to the need to implement Sepsis Six:

Unfortunately, Nervecentre (a national system) does not allow for this. However, RCHT is implementing a new e-Care digital electronic patient record (EPR) system and the Sepsis Lead Nurse will be involved in the implementation to develop a sepsis alert/trigger to digitally 'flag' when the 'Sepsis Six' needs to be actioned.

Additional Actions taken:

Following the death of Mr Clemens, the following actions have also been taken:

1. ESR Sepsis training to be undertaken by all staff on the renal unit.	Complete 100%
2. Supply of 1st line broad spectrum antibiotic to be kept on the renal unit.	Complete
3. Acute Sepsis Screening tool 16+ to be kept on renal unit.	Complete- attached to all Haemodialysis machines
4. Sepsis screening tool- the Sepsis Six to be available on the renal unit.	Complete-Nervecentre & paper
5. Sepsis box available on renal unit.	Complete
6. Paper News2 charts to be available on the renal unit.	Complete
7. Internal transfer telephone handover sheet to be completed in full for all patients admitted to an inpatient area from the renal unit.	Complete
8. Agree process with renal team for renal patients who become unwell whilst in dialysis.	Emergency OOHs SOP - complete Renal Unit RCHT Practice Standards for the Deteriorating Patient: A Clinical Guideline - complete
9. Educate staff on how to ensure escalations of concerns for patients are heard.	Complete- SBAR available for guidance Staff attending AIMs course as available

10. Escalation of care stickers to be available on renal unit to support conversations.	Complete
11. Audit of clinical observation recording to be undertaken by renal unit staff to ensure complete set of clinical observations are recorded.	Complete
12. Share patient safety review with Acute and Emergency Medicine Care Group Governance team and Head of Nursing.	Complete

To summarise the above, the Trust has taken the following actions:

1. The Standard Operating Procedure has been developed, approved and uploaded onto the Trust's intranet.
2. The Clinical Guideline determining the relevant pathway for a deteriorating patient on the renal unit has been developed and uploaded on the Trust's intranet.
3. The new E-Care digital electronic patient record will have a flag to alert when Sepsis Six is triggered. The current, national system (Nervecentre) does not allow for this.
4. The Trust has taken the additional actions listed above following the patient safety review following the death of Mr Clemens.

I hope that this letter provides both you and Mr Clemen's family with assurance that the Trust has taken seriously the matter of concerns you raised in your report and that the Trust has taken appropriate action to prevent future deaths.

Yours Sincerely

[redacted]

[redacted]
Chief Medical Officer
Royal Cornwall Hospitals NHS Trust