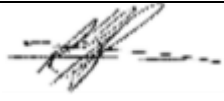


REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT DATED 31 MARCH 2025 IS BEING SENT TO:</p> <p>Chief Executive – Royal Devon University Healthcare NHS Foundation Trust. Chief Executive – Somerset NHS Foundation Trust (Musgrove Park Hospital).</p>
1	<p>CORONER</p> <p>I am Philip SPINNEY, HM Senior Coroner, for the coroner area of The County of Devon, Plymouth and Torbay.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 25 May 2022 an investigation was commenced into the death of Andrew James Tizard-Varcoe. The investigation concluded at the end of the inquest held on 25-27 March 2025. The conclusion of the inquest was as follows:</p> <p><i>Andrew James Tizard-Varcoe died due to complications of necrotising otitis externa</i></p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Andrew James Tizard-Varcoe had a complex past medical history. In April 2021 he was diagnosed with the ear infection otitis externa. Between April 2021 and May 2022 he received treatment across three hospital trusts whilst he was also being treated for other health conditions. Despite the treatment the infection progressed and entered the bones in his skull. On 11 May 2022 he died at his home address in Croyde, Devon, due to the progression of the infection.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows:</p> <p>(1) The evidence shows that Mr Tizard-Varcoe's overall treatment for the ear infections between April 2021 and May 2022 was provided across three different health trusts and hospitals, Musgrove Park in Taunton, North Devon District Hospital in Barnstable and Exeter Hospital; it is acknowledged that this was as a consequence of Mr Tizard- Varcoe's</p>

	<p>vascular disease (being treated at Musgrove Park) and the locations of specialist doctors. Whilst being treated at Musgrove Park for a vascular problem, Mr Tizard-Varcoe consulted with ear nose and throat specialists for ear pain; subsequently between April 2021 and May 2022 he was seen on a number of occasions by clinicians in all three locations; this led to occasions when Mr Tizard -Varcoe was reviewed by clinicians without the full clinical picture due to the inability of separate hospital trusts to access each other's medical records. The evidence revealed that on occasions it was difficult for Mr Tizard-Varcoe's GP to work out who had responsibility for his care. It is my judgement that on occasions this led to less than optimal treatment for Mr Tizard Varcoe.</p> <p>(2) In addition, the evidence revealed that there were three occasions when Mr Tizard-Varcoe was not followed up as an outpatient in a timely manner (August 2021, November 2021 and February 2022). On one occasion Mr Tizard-Varcoe possibly ran out of antibiotic medication and on another Mr Tizard-Varcoe was discharged without antibiotic medication. The lack of timely follow up appointments resulted in reduced monitoring and assessment and a poor understanding of the effectiveness of treatment and the progression of his ear infection.</p> <p>(3) In addition, on the 1 November 2021, Mr Tizard-Varcoe was discharged from the Royal and Devon Hospital without a prescription for oral antibiotics despite advice from microbiologists to do so; the evidence showed that this was a clinical decision made by a junior ear nose and throat doctor against an improving clinical picture. The discharge was overseen by a consultant from a different specialism due to Mr Tizard-Varcoe's health needs at the time.</p> <p>Evidence at the inquest from the responsible ear nose and throat consultant, indicated that he would probably have prescribed antibiotics on advice of microbiologists. Due to the progression of the infection from the ear canal into the bone at the base of the skull there is a real possibility that the clinical presentation did not reflect the true situation and this was a missed opportunity to provide continuity of treatment.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>(1) Consideration should be given to reviewing the process of managing and treating patients with multiple health conditions, being treated across different hospital trusts, to ensure greater coordination, collaboration and optimal treatment.</p> <p>(2) Consideration should be given to reviewing arrangements for follow-up outpatient appointments in the ear, nose and throat departments in the Royal Devon University Healthcare NHS Foundation Trust and the Somerset NHS Foundation Trust, to ensure effective monitoring.</p> <p>(3) Royal Devon University Healthcare NHS Foundation Trust to consider reviewing the arrangements for patient discharge in circumstances where a patient is being treated across different specialisms, to ensure that there is consultant oversight in all areas of ongoing treatment.</p>

	In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th May 2025. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the family and the Chief Coroner.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
	<p>SIGNED:</p> <p></p> <p>Mr Philip C Spinney HM Senior Coroner</p>