REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF JASON JAMES CLEMENS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS [redacted], Chief Executive Officer Royal Cornwall Hospital
1	**CORONER** **I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.**
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 28 March 2024 I commenced an investigation into the death of 54-year-old Jason James Clemens. The investigation concluded at the end of the inquest on 5 June 2025. The medical cause of death has been established on the evidence as follows *1a Pneumonia* *1b Cystic Fibrosis* *II Renal Failure (on dialysis)* The four questions - who, when, where and how – were answered as follows … *Jason James CLEMENS died on 23 March 2024 at Royal Cornwall Hospital Truro from complications following cystic fibrosis contributed to by a delay in the administration of antibiotics from the time of prescription. Antibiotics were prescribed to be administered without delay at 18:15 hours on 22 March 2024. There was a 7-hour delay before antibiotics were administered at 01:20 hours on 23 March 2024. Jason became unresponsive at 05:00 hours and died at 06:30 hours on 23 March 2024.*

	There were a number of missed opportunities to identify the requirement to administer antibiotics. This delay likely hastened Jason's death and more than minimally contributed to Jason's cause of death. The conclusion of the inquest was as follows *Natural causes contributed to by neglect.*
4	**CIRCUMSTANCES OF THE DEATH** There were four missed opportunities to administer antibiotics. The inquest found that Jason was a highly vulnerable patient due to his complex medical conditions. Jason suffered a medical episode during the afternoon of 22 March 2024 whilst attending an out-patient appointment at the renal unit of RCHT. Staff took clinical readings and requested a medical review which was completed by a renal registrar at 18:15 hours that day. The registrar gave instructions on Jason's medical management plan which required a full sepsis screen and the immediate administration of antibiotics. This was reinforced by the registrar completing a without delay prescription of antibiotics on the digital system (known as EPMA). Subsequently there were four missed opportunities to administer antibiotics before they were administered at 01:20 hours following day, 23 March 2024. Jason was found unresponsive at 05:00 and died at 06:30 on that day. The four missed opportunities were as follows 1) The renal registrar did not verbally instruct the nursing team to administer antibiotics at 18:15 hours. 2) The renal unit nurses either disregarded or did not read the registrar review and the management plan and EPMA prescription requiring immediate administration of antibiotics. 3) At 22:15 there was a handover from renal unit to acute medical unit (AMU). The renal unit nurses did not record on the handover notes the requirement to administer antibiotics. 4) On handover the AMU nurses either disregarded or did not check the management plan and EPMA prescription requiring the administration of antibiotics. The error was discovered on registrar review in the AMU at 00:10 hours the next day but there was then a further inexplicable delay. Antibiotics were administered at 01:20 hours, Jason became unresponsive at 05:00 and died shortly thereafter. The court found that these were basic errors and that the delay in the administration of antibiotics likely hastened Jason's death and more than minimally contributed to Jason's cause of death.
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. – The hospital accepted that there were failings that contributed to Jason's death. Measures to address those failings had not been fully implemented at the date of the Inquest. There were no applicable standard operating procedures for worsening patients in the renal unit at the date of Jason's death and none had been implemented by the date of Inquest. Jason died on 23 March 2024. The inquest was held on 5 June 2025. The court was told that the standard operating procedures are still being drafted in relation to identifying the appropriate pathway for the admission of worsening patients in the renal unit. The clinicians were undecided on applicable processes including whether the emergency department should be the default pathway. The court found on the evidence that moving worsening patients out of the renal unit and onto in-patient facilities is imperative and should be done at the first available opportunity. Such action would reduce the risks of medication and treatment errors and delays such as that which occurred in Jason's case. Delays due to uncertainties about appropriate pathways raises risks to patients who require the specialist treatment available on in-patient facilities. I note similar concerns have been raised in a previous Regulation 28 Preventing Future Deaths report issued following the death Mr M.R. Jervis, [PFD dated 30.12.2024]. This earlier R28 report noted failings by AMU and other nursing staff to administer antibiotics when clinical observations repeatedly indicated such was required. The Jervis R28 report raised a concern regarding the absence of a digital alert on hospital software, which could have alerted staff to the need to implement sepsis six, including the need to administer antibiotics. It is unclear whether this measure has been introduced and if not, whether a digital alert would have made a difference in Jason's case.
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 28 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 have sent a copy of my report to the Chief Coroner and to the family. 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	**2 July 2025**	**HMC Guy Davies**