REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

Recipients

This report is being sent to:

Chief Executive, Torbay Hospital
Secretary of State, The Ministry of Health

Coroner

I am IAN MICHAEL ARROW, Senior Coroner for the area of Plymouth, Torbay & South Devon

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

Investigation and Inquest

On the 7th May 2013 I commenced an investigation into the death of Stephen Anthony Allardice Widman aged 63. The investigation concluded at the end of the Inquest on 23rd April 2014

The cause of death was found to be:

1a Sepsis
1b Urinary tract infection with pyelonephritis
1c Carcinoma of the rectum (operated 13.3.13.) abdominal-perineal excision after chemo-radiotherapy; urethral tear noted and repaired.

The conclusion of the Inquest was that a Narrative was recorded namely: During ongoing treatment the deceased was catheterised on several occasions. Infection developed. The deceased deteriorated and died in Torbay Hospital, Torquay on the 26th April 2013.

Circumstances of death

The deceased had been suffering from carcinoma of the rectum. That was treated. The deceased had been catheterised and was catheterised repeatedly thereafter. On the balance of probability a catheter was inappropriately placed. Infection developed. The deceased was weakened through contraction of pneumonia.

Coroner's concerns

The matters of concern are as follows:

1. There should be an accelerated pathway for individuals suffering neuropenic sepsis so they are dealt with promptly. On the evidence at this Inquest it was inappropriate for the deceased to sit for several hours in the Accident and Emergency Department.

2. The deceased was catheterised too frequently without the management of a urologist.

Evidence was received that there is an advantage in treating patients promptly on arrival at Accident and Emergency and that treatment could be expedited if patients were issued with a card noting their vulnerability and bringing with them a contact telephone number.

Action should be taken

Evidence was received that a Consultant could issue a vulnerable patient (particularly patients who are vulnerable because of cancer treatment) with a card to present at an Accident and Emergency Department which would read to the effect "I am vulnerable because .... please contact x on my behalf". The evidence received was that this would be particularly helpful during weekends. The issue of such cards should be at the discretion of the Consultant having care of the patient.

I would ask Torbay Hospital and the Minister to consider the appropriateness of the issue of such cards.

Action should betaken

In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.

Your response

You are under a duty to respond to this report within 56 days of the date of this report namely, 24th June 2014. 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.

Copies and publication

I have sent a copy of my report to The Chief Coroner and to the following interested persons

[redacted] Dittisham, South Devon

I am under a duty to send the Chief Coroners 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 to the Chief Coroner

I.M. ARROW **Dated 29th April, 2014**
Senior Coroner – Plymouth, Torbay & South Devon