REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, c/o New Cross Hospital, Wolverhampton, West Midlands, WV10 0QP**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 22 August 2016, I commenced an investigation into the death of the late Mr Vinod Kumar. The investigation concluded at the end of the inquest on 12 October 2016. The conclusion of the inquest was a short narrative conclusion of accidental death. The cause of death was: 1a Multi-Organ Failure b Group A Streptococcus Septic Shock c Necrotising Fasciitis secondary to laceration sustained from fall
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Kumar was a very active and healthy family man who attended the gym and kept fit. ii) On or around the 4 August 2016, he was complaining of feeling unwell with flu like symptoms. Unusually for him, this resulted him taking time off work. iii) The following day he had a fall at home and sustained a graze to his right arm/elbow. His condition continued to decline and he attended New Cross Hospital on the evening of the 9 August 2016 after previously seeing an out of hours GP who suggested he had a viral infection which would resolve in several days. iv) In the Accident and Emergency Department, he was initially seen by a Triage nurse who categorised him as a level 4 (least urgent) and took his history including a fall and swollen/painful arms. v) He was seen later that night by a Doctor and after blood tests it became apparent he had a serious infection/sepsis. vi) After further tests and x-rays, a fracture was ruled out and at this stage he

	was extremely ill and in multi-organ failure. vii) His condition declined further and sepsis secondary to necrotising fasciitis was diagnosed. viii) Despite surgical intervention to remove the infected tissue, he died shortly after the surgery on the 10 August 2016. ix) On the balance of probability, the likely source of necrotising fasciitis was the graze on the arm injury.
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. – 1. Evidence emerged during the inquest that when he was seen initially by the Triage nurse, that too much emphasis and reliance was placed on the significance of the fall/trauma. Evidence of potential infection (swelling to his arms) resulted in no further observations or blood tests done until some three hours later. 2. Evidence from the A and E Consultant emerged from the inquest which suggested that it would have been good practice to keep the patient under further observation before determining his level of priority in terms of categorisation.
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. 1. You may wish to consider reviewing your policy/guidelines in respect of the current sepsis policy, particularly in light of what happened to Mr Kumar. Evidence of swelling to his arms and the history given may have triggered an earlier blood test and observations.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 December 2016. 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 following Interested Persons; Mrs Kumar. 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	**17 October 2016** **Mr Z Siddique** **Senior Coroner** **Black Country Area**