REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Jennifer Withey, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England** **2. NHS Pathways**
1	**CORONER** I am Andrew Cox, Acting Senior Coroner for the coroner area of Cornwall and 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 14/12/17, an inquest was opened into the death of Jennifer Mary Withey who died in Royal Cornwall Hospital Truro on 10/9/17. The inquest culminated in a final hearing on 25 & 26 June 2019 with a narrative conclusion being recorded namely, that Jenny died from a known complication (infection) of an elective surgical procedure. The cause of death identified at post-mortem was: 1A) sepsis 1B) middle back abscess formation 1C) spinal fusion operation (postop) II immunosuppressive drug intake
4	**CIRCUMSTANCES OF THE DEATH** Jenny had a past medical history that included rheumatoid arthritis for which she was in receipt of immunosuppressant medication. She had a long-standing back complaint and underwent spinal fusion in Derriford Hospital, Plymouth at the end of July 2017. In mid-August 2017, the wound was noted to have broken

	down and she had a washout. She rang the 111 service on three occasions over 2 & 3 September 2017. On audit, two of those calls were identified as under compliant. At inquest, I heard from [redacted] the Medical Director for South-West Ambulance Service Trust, then responsible for the 111 call handlers. During one call, it was recorded that Jenny had worsened from a call made the previous day, could no longer weight bear, had not passed urine for 30 hours and said her left arm and leg felt dead. These matters were recorded in a free text box available for use as part of the NHS Pathways process. In error, the call adviser failed to recognise that this was a complex call and accordingly, did not immediately refer to a clinician. It was also recognised that the three matters recorded in the free text box were all potential signs of sepsis – from which Jenny subsequently died. It was further noted in evidence that the 111 service was separate and distinct from Cornwall Health (Devon Docs) who then provided the out of hours GP service. Both organisations operated within their own timeframes. By way of illustration, the disposition could be reached by a call handler that a patient needed to be contacted by primary care within two hours. The GP could then decide, after speaking to the patient, that an ambulance was required and should attend within a further two hours.
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. – A) The free text box could be set up so that identified symptoms, where appropriate, could generate an automatic red flag. By way of illustration, a non-blanching rash could automatically justify immediate hospital admission by ambulance in a case of suspected meningitis. Similarly, in this case, where a number of sepsis indicators were present, a red flag could have been raised requiring the call adviser specifically to consider a sepsis pathway. This would act as a second level of security, the first step being to allocate a patient to a correct pathway in the first instance. B) is it possible to establish a single patient orientated pathway with a key performance indicator of, for example, 'patient to be seen within two hours' rather than two separate time limits for two or more organisations (here, 111 and Cornwall Health) which cumulatively introduces unnecessary and avoidable delay into the process.

6	**ACTION SHOULD BE TAKEN** 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. Would you please consider whether there is merit in using keywords in the free text box to trigger automatic red flags in prescribed circumstances. Would you also please consider whether it is appropriate to have a single patient orientated pathway rather than multiple performance indicators where there are a number of different service providers.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 02/09/2019. 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: [redacted] SWAST, Royal Cornwall Hospital. 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	**[DATE]** **03/07/2019** **[SIGNED BY CORONER]**