	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **East Lancashire Hospitals NHS Trust** **The family of Mr Frank Medley** **CQC**
1	**CORONER** I am **Dr James Adeley, Senior Coroner** for **Lancashire & Blackburn with Darwen**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16 July 2019 I commenced an investigation into the death of Mr Frank Charles Medley aged 81 years. The investigation concluded at the end of the inquest on 23 February 2021. The conclusion of the inquest was natural causes. 1a Respiratory Arrest 1b Tetsaporesis and spinal cord injury due to spinal cord collection 1c Falls II Hiatus hernia, Barretts oesophagus, Osteoarthritis
4	**CIRCUMSTANCES OF THE DEATH** Mr Medley presented on 2 July 2019 with acute onset weakness in all four limbs. The admitting consultant physician appreciated the urgency of the situation and ordered an MRI scan. Despite the consultant physician and consultant radiologist agreeing that the scan should be undertaken within 24-hour's according to NICE guidance, the scan did not take place for four working days. There is minimal evidence from the hospital records of the junior doctors request for the priority of the scan to be changed and the consultant made no personal attempt at any point to expedite the scan. The evidence of the consultant neurosurgeon was that this did not affect the outcome. Mr Medley underwent surgery on 9 July 2019 where multiple paraspinal abscesses were drained. Mr Medley died on 14 July 2019. A full account of the circumstances of the death is contained in the attached summing up.
5	**CORONER'S CONCERNS**

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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) The Trust has an ineffectual system to detect adverse outcomes where the patient is transferred to a tertiary centre for treatment and subsequently dies;

(2) The Trust's review of this case was seriously deficient in the following instances:

a. At no point were members of the family spoken to for their views or concerns regarding the death up to and including the inquest.
b. The date of death was 14 July 2019. The Report was incomplete eight months later in March 2020 when it was suspended during the first Covid wave. The report was not completed before the inquest on 23 February 2021. This is not in accordance with NHS guidance;
c. The case was inappropriately allocated to a structured judgement review;
d. The "Summary of the Incident" contains substantial factual inaccuracies to such an extent that it is deeply misleading;
e. Mr Medley's death was due to complications of sepsis. The report failed to note that due to admission for query sepsis at the same hospital 11 days before, that:
    i. the EWS score was sufficient to trigger the septic shock pathway;
    ii. the nurse correctly identified that the septic shock pathway should be followed and drew this to the attention of "a doctor";
    iii. that due to the referrals taking place between specialties at this time the relevant speciality responsible for dealing with this issue cannot be identified and made no entry in the medical records (this raises similar issues to those concerns raised in the Regulation 28 report concerning Mrs Gillian McKinley at the same Trust);
    iv. that, despite the patient observations being readily available to the treating consultant orthopaedic surgeon the following morning and the nurse having documented the septic shock pathway should be activated in the notes, the consultant orthopaedic surgeon failed to note this both at the time and during the preparation of his witness statement for the inquest;
    v. the error was only detected by the Trust's Legal Services Department when preparing for the inquest 19 months after the event.
f. That the consultant physician responsible for Mr Medley's care appreciated that his symptoms constituted a medical emergency, that the MRI scan should be completed on 2 July 2019 but took no action himself to expedite the scan. There is no documented evidence in the medical records regarding junior doctors attempts to expedite the scan;
g. The consultant physician responsible for Mr Medley's care after input from the neurologists on 3 July 2019 made no attempts to expedite the scan or to contact tertiary neurosurgical services;
h. On 2 July 2019 the treating clinicians suspected infective complications high in the cervical spine but only undertook a chest x-ray and blood cultures without considering sending a urine sample for analysis, considering an echocardiogram or OPG:
i. Mr Medley's scan should have been completed within 24 hours of request in accordance with NICE guidance, which was not cited anywhere in the report, and that the priority attached to the scan on 2 July 2019 placed Mr Medley in the lowest priority category when he should have been in the highest priority category. This mistake was repeated on 3 July 2019 when Mr Medley was placed in the middle

		priority category. There is no documentation as to any rationale for the priority allocation; j. The scan when it was performed on 5 July 2019 was not a contrast scan necessary to accurately delineate foci of infection resulting in a further scan using contrast to be performed later that day. k. That prioritisation of scans within the radiology department depended to a considerable extent on a personal attendance by clinicians at the department or speaking to radiologists rather than solely on clinical need; and l. There was insufficient senior clinical oversight of the conclusions drawn. (3) The Department undertaking reviews of adverse incidents appears to operate independently from the Legal Services Department (4) The delay in obtaining the scan was partly attributed to a lack of MRI scanner capacity. At the inquest the Trust could only provide conjecture as to whether or not alterations to scan capacity had made any difference to the time taken to obtain urgent scans.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the Medical Director has the power to deal with the above concerns
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **27 April 2021**. 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 CQC and family who may find it useful or of interest. 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	Dated 2 March 2021  Signature **HM Senior Coroner for Lancashire & Blackburn with Darwen**

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