IN THE MILTON KEYNES CORONER'S COURT

INQUEST into the death Of Nicholas Rousseau

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Milton Keynes University Hospital**
1	**CORONER** I am Dr Séan Cummings Assistant Coroner for the Coroner Area of Milton Keynes
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 14th October 2019 an Investigation was opened into the death of Mr Nicholas Rousseau who died on the 9th October 2019. The medical cause of death was given as 1a) Acute Bowel Ischaemia 2 Duodenal Ulcer; Ischaemic Heart Disease and the Inquest was held on the 2nd February 2021. The Inquest Conclusion was one of natural causes.

4	**CIRCUMSTANCES OF THE DEATH** Mr Rousseau attend the Milton Keynes University Hospital on two occasions on the 3rd and 5th October 2019 and died at home on the 9th October 2019. He was aged 47 years of age. On the 3rd October 2019 when assessed in the Accident and Emergency he was found to have a venous blood gas lactate level of 3.9. Lactate is one of the measures of sepsis. Mr Rousseau was discharged.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) In the course of oral evidence Dr [redacted] and [redacted], both Consultants in Accident and Emergency Medicine at the hospital gave conflicting accounts of how much importance they would ascribe to the lactate level which was nearly twice the upper limit of normal and whether they would repeat it before discharge. [redacted] told me he would not repeat it because he saw lots of patients with elevated lactate and with the resources he had available he would be spending a disproportionate amount of time checking lactate levels in patients who ultimately would be fine. We spent some time on the point and with reference to the NICE Sepsis Risk Stratification Tools. The Guideline is clear that if a lactate is above 2 then the patient should be escalated to high risk. [redacted] was challenged several times on his position that irrespective of the guidelines he would not routinely repeat the lactate level dismissing it as an unnecessary burden. He maintained that position. Dr [redacted] took a flatly contrary view and said that she would repeat it irrespective of the burden of work it may generate. These contrasting opinions indicate a degree of confusion amongst the senior staff at Milton Keynes University Hospital Accident and Emergency Department which in my view poses a threat to patients with sepsis and with elevated lactate levels. The disregarding of the NICE Guidelines simply because it is inconvenient is disturbing.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (1) [redacted], The Chief Executive the Milton Keynes University Hospital 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 24rd May 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 (1) The Rousseau family (2) The Milton Keynes University 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	**28th March 2021** Dr Séan Cummings Assistant Coroner Milton Keynes