	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Medical Director, University Hospital Lewisham, Medical Director's Office, Lewisham High Street, London SE13 6LH
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** I opened an inquest into the death of Mr Yusuf Seyit, ([redacted] and [redacted]), who died on 3rd July 2019 aged 72 years on 12th September 2019. The delay in holding the inquest was ascribed to the impact of the Covid pandemic. The medical cause of death was: 1a Septicaemia 1b Urinary Tract Infection II Immunoglobulin G4 disease, Myelodysplastic syndrome, Diabetes Mellitus. The narrative conclusion was natural causes was contributed to by a delay in administering antibiotics in septic shock.
4	**CIRCUMSTANCES OF THE DEATH** Mr Seyit suffered from multiple diseases which immunosuppressed his response to infection and had been in hospital since January. The family reported pain on passing urine on 30th June. He had an indwelling catheter and a urine infection was suspected on 1st July, when he had suprapubic tenderness as well as signs suggestive of a chest infection. The urine result was reported at 17.50 on 2nd July as highly resistant E coli, sensitive to Amikacin. At this time he was stable but there was an indicator of infection – the slightly elevated CRP of 23. He acutely deteriorated at 05.00 with septic shock and a medical review concluded at 06.25. He was prescribed three antibiotics (he had a chest infection as well) including Amikacin. It is not known when in the morning Amikacin was administered. He died at 20.00
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – 1. He was known to be at high risk of fatal infection and had developed symptoms 2 days before death and definitive proof of infection by the late afternoon of 2nd July, but it was not clear whether there was a plan for antibiotic intervention and no treatment was begun that day.

	2. When in septic shock in the early hours of 3rd, three antibiotics were prescribed and our initial death report indicated treatment had begun before he died. But the medical records available to the inquest did not confirm when Amikacin was actually administered. Evidence of a consultant physician was that it needed to be within an hour.
6	**ACTION SHOULD BE TAKEN** The coroner draws attention of The Trust, with the family's support, to the need to ensure that appropriate antibiotics for septic shock are available within the hour after prescription at any time of day or night. It may be that this facility is in operation but the evidence not adduced. In any event the Trust may wish to assure the public of the processes of securing administration of life-saving medication for sepsis at all times.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday, 11th June 2021. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: [redacted] inquest coordinator, UHL I am also sending this report to the following, who have an interest and may be in a position to offer advice on mitigating such tragedies: Royal College of Physicians. 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]** **[SIGNED BY CORONER]** **16th April 2021** **Andrew Harris, Senior Coroner**