	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Dr [redacted] Medical Director Blackpool Teaching Hospitals NHS Foundation Trust
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for Blackpool & Fylde
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** The death of Coral Amy O'Donnell on 17th May 2019 was reported to me and I opened an investigation, which concluded by way of an inquest held on 29th April 2021. I determined that the medical cause of Elliot's death was 1a Panton valentin leukocidin staphylococcus aureus pneumonia b Influenza A c II Critical care acquired myopathy The conclusion of the Coroner was that Coral died due to natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances were set out in box 3 of the Record of Inquest as follows: Coral O'Donnell was regarded as previously healthy but was known to be susceptible to developing skin infections. She had attended a General Practitioner in early November 2018 in relation to an abscess for which she was prescribed antibiotics. On 8th January 2019 Coral was assessed by a nurse having presented with cough and cold like symptoms and after examination was felt to have developed a viral infection. After a deterioration in her condition during 10th January 2019 Coral was admitted to hospital in Blackpool that evening where investigations revealed she was neutropenic and concerns were raised she has severe pneumonia. By the next morning she required intubation and ventilation. Her history of skin infections, a known indicator of a very rare bacterial infection, was not appreciated during the early part of her admission until around 21st January 2019 when a concerning CT scan confirmed that this infection had been seriously damaging Coral's lungs and in the absence of necessary mediation. Over subsequent weeks Coral's condition fluctuated but she remained seriously unwell. Despite months

	of intensive care, she could not be successfully weaned from ventilator support. Her condition began to deteriorate further in early May 2019 before Coral died in the company of her family on 17th May 2019.
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 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. – • That when evidence of Staphylococcus Aureus was identified the clinical and microbiology teams did not consider the possibility of Panton Valentine Leukocidin (PVL) Staphyloccus Aureus, despite Coral's history of skin infections and the severe pneumonia she presented with on admission in a previously young fit woman. • That there was a lack of awareness of PVL amongst senior clinicians, despite the fact that a senior Microbiologist from the hospital Trust confirmed that national guidance covering the treatment of such condition was in use at the Trust at the time, but none of the critical care team who gave evidence at the inquest seem to have been aware of that document. Although the court was told this has now been rectified there is a concern that some clinicians are unfamiliar with hospital protocols which may be relevant to their work; • That communication between the critical care and microbiology teams was problematic and neither team considered PVL until there was established damage to her lungs identified on a chest x-ray. Senior clinicians had not mentioned a susceptibility to skin infections to the microbiologists which may have resulted in Coral receiving the correct treatment at an early stage of admission. The lack of communication between Microbiology and the clinical team appears to have in part been contributed to by a previous cessation of the thrice weekly joint microbiology and critical care ward rounds, which the court heard have not been re-instated; • That the number of microbiologists at the time of Coral's admission was limited – a senior Microbiologist told the court her team ought to comprise six microbiologists, but were limited to a maximum of four at the time and that remains the case. • That there was a stark lack of awareness, noticeably amongst senior clinicians, about internal systems in place at the hospital Trust. The court heard about the Cyberlab system, and also a red flag system which the court was told a number of critical care clinicians had previously been unaware of. If clinicians have not received the necessary training in relation to such systems there is a risk they may not recognise potentially relevant information, placing patients at potential risk.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday, 6th July 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: • The Parents of Coral Amy O'Donnell • Nurse Practitioner [redacted] • Dr [redacted], GP 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, 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:11/05/2021 Signature_____ A A Wilson _____ Alan Anthony Wilson Senior Coroner Blackpool & Fylde