

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Dr. [REDACTED] Clinical Director, NHS Blackpool and NHS Fylde and Wyre Clinical Commissioning Groups, Blackpool Stadium, Seasiders Way, Blackpool, FY1 6JX</p>
1	<p>CORONER</p> <p>I am Alan Anthony Wilson Senior Coroner for Blackpool & Fylde</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>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.</p> <p>I determined that the medical cause of Elliot's death was</p> <p>1a Panton valentin leukocidin staphylococcus aureus pneumonia b Influenza A c II Critical care acquired myopathy</p> <p>The conclusion of the Coroner was that Coral died due to natural causes.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The circumstances were set out in box 3 of the Record of Inquest as follows:</p> <p>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</p>

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.

In addition, I made the following findings:

- That Coral's consultation with a GP, Dr [REDACTED], in early November 2018 was conducted in what appears to have been a proportionate manner;
- That although an expert witness told the court that the Panton Valentin Leukocidin [PVL] strain of staphylococcus aureus [SA] often follows flu – like symptoms and may affect otherwise healthy young people, I made no criticism of the fact the GP did not know about PVL, particularly having considered the rarity of the condition and the evidence of other experienced doctors seemingly unfamiliar with PVL and by an independent GP who had never heard of it before;
- That an independent microbiologist told the court that PVL – SA should be suspected if there is evidence of recurrent abscesses. He added that SA is a common bacterial infection, but the PVL is uncommon.
- That although no referral had been made to a dermatologist, no criticism was made of this decision. The conduct of medical professionals who had assessed Coral before her hospital admission had been considered by an independent GP;
- However, evidence was received that had such a dermatology referral been made, this may have resulted in the earlier recognition of PVL.


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. –

- Although Staphylococcus aureus is a common bacterial infection, for the PVL strain of that infection to lead to the lung damage suffered by Coral is very rare. Nevertheless, one of the symptoms which may give medical professionals an indication that a patient may be at risk of PVL – SA is a history of skin infections and in otherwise healthy young people. There is clearly a lack of awareness of this condition in both primary and secondary care and in the absence of efforts to highlight this issue, young people such as Coral may continue to be placed at risk.
- The court was told that there is a Public Health England publication entitled "Guidance on the diagnosis & management of PVL – associated Staphylococcus aureus infections", but amongst medical professionals any awareness of this guidance appears to be limited.

6 ACTION SHOULD BE TAKEN

	<p>In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><u>YOUR RESPONSE</u></p> <p>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.</p> <p>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.</p>
8	<p><u>COPIES and PUBLICATION</u></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ul style="list-style-type: none"> • The Parents of Coral Amy O'Donnell • Dr [REDACTED], Medical Director, Blackpool Teaching Hospitals NHS Foundation Trust • Nurse Practitioner [REDACTED] • Dr [REDACTED], GP <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Date: 11/05/2021</p> <p>Signature _____  _____</p> <p>Alan Anthony Wilson Senior Coroner Blackpool & Fylde</p>