REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. One Medical Group** **2. The Secretary of State for Health**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (E).
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 Thursday 6th February 2020 I commenced an investigation into the death of Alexander George Theodossiadis, aged 25. The investigation concluded at the end of the Inquest on Friday 3rd December 2021. The conclusion of the Inquest was a narrative based upon the cause of death of 1(a) Disseminated Sepsis 1(b) Streptococcus Pneumoniae Meningitis and 2) Subdural Haemorrhage.
4	**CIRCUMSTANCES OF THE DEATH** Alexander George Theodossiadis aged 25 was unable to get a GP appointment for some three weeks when he telephoned the GP Surgery on 20th January 2020. He attended a walk-in centre on 24th January 2020 where he was examined and diagnosed with a viral infection. The following day his flat mate took him to A&E where he was admitted and treated for bacterial meningitis. Later the same day he was transferred to another hospital but arrived without a written handover. Within minutes of being placed in a side cubicle in a confused state, he fell from the hospital bed and sustained a head injury. Within a short time, he lost consciousness. His condition deteriorated markedly due to a combination of meningitis infection and a bleed on his brain. He died in hospital on 28th January 2020 after active treatment was withdrawn.
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 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 Inquest heard evidence that when Mr Theodossiadis sought an appointment with a GP, he was only able to get one in three weeks time. He did not venture any details of his symptoms. Nor, however, did the GP's receptionist probe to obtain any information which would help to assess the urgency of the situation or the priority to be given to his request. Within six days of this telephone call, Mr Theodossiadis was irretrievably overwhelmed with a meningitis infection. (2) GP receptionists must strike a difficult balance between respecting medical confidence and obtaining sufficient information to enable a judgement to be made in relation to access to medical help. In the case of fast-moving medical conditions such as meningitis afflicting otherwise healthy young people the Inquest heard concerns expressed that refresher training was regularly required but may not be provided with sufficient frequency to maintain vigilance at this important interface between patients and clinicians.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 Monday 7th February 2022. 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) Professor and Dr [redacted] 2) Royal College of General Practitioners, Royal College of General Practitioners, 30 Euston Square, London, NW1 2FB 3) NHS England, NHS England, PO Box 16738, Redditch, B97 9PT 4) The Light Surgery, Balcony Level, The Light, The Headrow, Leeds, LS1 8TL. I have also sent it to: 1) The Yorkshire Post 2) [redacted], Bauer Media 3) [redacted], Press Association 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	Signed: Kevin McLoughlin Dated: 3rd December 2021

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. **Leeds Teaching Hospitals NHS Foundation Trust** 2. **The Secretary of State for Health**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (E).
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 Thursday 6th February 2020 I commenced an investigation into the death of Alexander George Theodossiadis, aged 25. The investigation concluded at the end of the Inquest on Friday 3rd December 2021. The conclusion of the Inquest was a narrative based upon the cause of death of 1(a) Disseminated Sepsis 1(b) Streptococcus Pneumoniae Meningitis and 2) Subdural Haemorrhage.
4	**CIRCUMSTANCES OF THE DEATH** Alexander George Theodossiadis aged 25 was unable to get a GP appointment for some three weeks when he telephoned the GP Surgery on 20th January 2020. He attended a walk-in centre on 24th January 2020 where he was examined and diagnosed with a viral infection. The following day his flat mate took him to A&E where he was admitted and treated for bacterial meningitis. Later the same day he was transferred to another hospital but arrived without a written handover. Within minutes of being placed in a side cubicle in a confused state, he fell from the hospital bed and sustained a head injury. Within a short time, he lost consciousness. His condition deteriorated markedly due to a combination of meningitis infection and a bleed on his brain. He died in hospital on 28th January 2020 after active treatment was withdrawn.
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 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) Evidence was taken at the Inquest which indicated Mr Theodossiadis was moved from one hospital within the Trust to another, close to midnight on 25th January 2020. Despite being severely unwell with bacterial meningitis and in a confused state he was not accompanied by a nurse escort, nor was any written handover instruction or briefing note provided for the nurses receiving him, in breach of the prevailing Trust handover guidance. (2) Mr Theodossiadis remained in A&E for some 10 hours in total, despite the nature of his condition. Concern was expressed at the Inquest in relation to firstly, the absence of clear instructions regarding the need for a lumbar puncture within four hours of admission; secondly, a clear pathway to an appropriate treatment location; thirdly, any directions specifying the timetable in which action was required in response to a life-threatening condition.

	(3) The Inquest heard evidence that practice differs nationally on the need for a lumbar puncture in cases of meningitis. The absence of clear leadership on this issue nationally does not assist clinicians who may encounter this relatively rare, but serious condition. (4) Despite spending 10 hours in A&E and displaying increasing signs of confusion he was seen to be trying to get off his hospital bed which created a risk of falls, no assessment of the falls risk was carried out. In consequence, the receiving ward J27 at St James's University Hospital, Leeds were not forewarned of the risk of falls. He fell from his hospital bed within approximately 10 minutes of being placed in a side room on his own.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 Monday 7th February 2022. 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.
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9	Signed: Kevin McLaughlin Dated: 3rd December 2021