Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS **REPORT IS BEING SENT TO:** **1 [redacted], CEO Atrumed Ltd** **2 [redacted], Chief Executive Bedfordshire Hospitals NHS Foundation Trust** **3 Nurse [redacted]**
1	**CORONER** I am Dr Sean Cummings, Assistant Coroner for the coroner area of Bedfordshire and Luton
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 06 May 2020 I commenced an investigation into the death of Mandy Jane DICKERSON aged 51. The investigation concluded at the end of the inquest on 01 December 2021. The conclusion of the inquest was that: Mandy Jane Dickerson died at home on the 30th April 2020 from sepsis. She had attended the Urgent GP Care Centre at the Luton and Dunstable Hospital on the 26th April 2020. The medical registrar declined to assess her and thus she was not treated. This was an avoidable death.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mandy Dickerson had presented to her GP via telephone consultation with a reported abnormal bruising on the 23rd April 2020. 2. She spoke with a different GP at the same practice the next day and complained of a 4 day history of diarrhoea and vomiting. The diarrhoea was profuse and frequent. She had not mentioned this the day before. 3. She attended the Luton and Dunstable Hospital ED on the 26th April 2020 and was "streamed" to the Urgent GP Care Centre by the streamlining nurse. 4. She had a wait of nearly one hour in the Urgent GP Centre reception before seeing the nurse practitioner. 5. Urine was taken and was abnormal. 6. When she saw the nurse practitioner she was noted to be extremely breathless which was attributed to her having rushed from the car park. Ms Dickerson is reported to have offered that as an explanation. However, as above, she had been waiting in reception for one hour. 7. At assessment she was pyrexial and tachycardic. 8. The nurse practitioner diligently recorded the observations and the consultation but did not record the oxygen saturations or the physical examination of the chest or

abdomen which he later referred to in his statement presented to the Court on the eve of the hearing.

9. The nurse practitioner reportedly spoke with the medical registrar on duty and the advice received was that because Ms Dickerson was tolerating oral fluids she did not need to be admitted and could be discharged home. The medical registrar could not be traced for statement or to attend the Inquest having apparently relocated to Sri Lanka.

10. Ms Dickerson was then sent home.

11. She had a further telephone consultation with her GP on the 28th April 2020 at which she reported an improvement. Her temperature was reported as being lower but she complained of exhaustion.

12. She died on the 30th April 2020 in the early hours of the morning.

I made the following findings:

1. I acknowledge that the Consultant Pathologist gave the medical cause of death as 1a Unascertained. However, having heard all the evidence I consider it overwhelmingly likely that Mandy Dickerson died of sepsis and so the MCCD will reflect that.

2. While the nurse practitioner stated in his statement and in oral evidence that he had taken the oxygen saturation measurements and also examined the chest and abdomen I find that he did not make those examinations. I say this partly because the rest of the contemporaneous note made was detailed and I find it implausible that if the additional examinations had been carried out that they would not have been recorded in the same diligent manner as the remainder.

3. Nonetheless he was worried and phoned the medical registrar for advice. The medical registrar did not have the benefit of seeing and examining Ms Dickerson and wrongly declined to see her. As Dr [redacted] put it rather aptly, the medical registrar is likely to have persuaded the nurse practitioner out of his worries allowing him to discharge Ms Dickerson home.

4. I find that the advice given by the medical registrar was inadequate and that Mandy Dickerson should have been seen and examined by a member of the medical team on the 26th April 2020. I note that the nurse practitioner was not asking for Ms Dickerson to be admitted but to be seen and assessed. Dr [redacted] and Dr [redacted], my expert, were in agreement that she should have been seen and assessed and that sending her home was the wrong course.

5. Had Ms Dickerson been seen and assessed on the 26th April 2020 by the medical team I consider it overwhelmingly likely that she would have been treated with fluids and antibiotics and also that she would have survived this illness.

5 **CORONER'S CONCERNS**

During the course of the investigation my inquiries 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:
(brief summary of matters of concern)

To the Chief Executive, Atrumed Ltd, provider of Urgent GP Care (UGPC) services on the Luton and Dunstable University Hospital site:

1. In my view there was considerable reluctance on the part of Atrumed Ltd, led by CEO [redacted], to engage properly with my investigation. This resulted in the issue of a Schedule 5 Notice to [redacted], to attend a special court session, so that I did secure his attention and to impress on him the significance of a Coroner's investigation and that his co operation was not optional, in large part to ensure future learning.

2. The computer system in use at the Urgent GP Care Centre was prone at the time (April 2020) to glitches which rendered the use of the "Sepsis template" to be "advised" rather than mandatory. Sometimes it would display and other times not. It is my view that had the Sepsis template been fully operational and mandatory then the signs of sepsis shown by Mandy Dickerson would have likely altered the clinical decision making and resulted in prompt treatment for sepsis with probable survival.

3. There was fundamental confusion with regard to the management of patients, out of hours, who the treating UGPC clinician felt should be assessed by a relevant speciality, in this case medical, and where the relevant speciality felt assessment was unnecessary. It was understood by [redacted] and by the treating UGPC nurse that once the speciality registrar had made a decision then that decision was final and the only option was to discharge the patient, unless they were in extremis, when a 222 call could be made for emergency assistance from the nearby hospital. I was told that if the patient was returned to the ED then the streaming nurse would simply refer them back.

That view was flatly contradicted by Dr [redacted], Consultant in Emergency Medicine at the Luton and Dunstable University Hospital and Deputy Medical Director. He told me it was entirely open to the UGPC staff to refer back to ED if there was difficulty. He did not accept that the ED would refuse to see patients referred back, saying it happened all the time.

4. There was in my view a failure to record and then to convey key information to the medical registrar who consequently may have given advice which was ill-informed. The nurse practitioner told me, in oral evidence and in a statement provided at the eleventh hour the night before the Inquest, that the measurements had been performed but simply not recorded. However, the remainder of the note was particularly and contemporaneously detailed with these critical observations being conspicuous by their absence. I found that the observations had not been made. In addition, no record was made of the name of the medical registrar making investigation of this element difficult.

To the Chief Executive, Bedfordshire Hospitals NHS Foundation Trust:

1. I heard detailed evidence of the "streaming" service where patients attending the ED were directed to the UGPC on the basis of very little information gained from their presenting complaint and basic "eyeballing" of the patient. I understood that there is a difference between streaming to UGPC and triage for entry into the ED. I also understood the impact of the pandemic on the provision of services. However, it was apparent that very little documentation of the process with regard to each patient is made, kept or conveyed.

2. I have referred in (3) above to the situation with respect to the referrals to the speciality registrars out of hours. I was provided with information about many different policies and procedures but I did not hear evidence as to any policy directing how a speciality registrar should respond to a request for assessment when even allowing for the missing important observations, enough information was conveyed to mandate (in Dr [redacted] and Dr [redacted] opinions) a medical assessment.

6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 May 30, 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 ou must ex lain wh no action is ro osed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to Ms Dickerson's partner [redacted] and her son [redacted]. I have also sent it to **Dr [redacted], Consultant in Emergency Medicine The Care Quality Commission** **Dr [redacted], Chair of the Bedfordshire, Luton and Milton Keynes CCG** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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. **Dated 3rd April 2022** **HMAC Dr Sean Cummings, Bedfordshire and Luton**
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