REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Medical Director, NHS Trafford Clinical Commissioning Group (CCG)
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 3rd September 2019 I commenced an investigation into the death of George Townsend. The investigation concluded on the 3rd March 2020 and the conclusion was one of **Narrative: Died from bronchopneumonia contributed to by the complications of antibiotic therapy, namely clostridium difficile not diagnosed until admission to hospital.** The medical cause of death was **1a) Multi organ failure 1b) Bronchopneumonia on a background of clostridium difficile diarrhoea due to antibiotic therapy; II) Peripheral Vascular Disease, Chronic Ulcers, Chronic Kidney Disease, Frailty, Chronic Obstructive Pulmonary Disease**
4	CIRCUMSTANCES OF THE DEATH George Townsend was on long term antibiotic therapy for ulcers arising from complications of peripheral vascular disease. On 1st August 2019 he developed diarrhoea. He telephoned the GP surgery for advice. His medication was changed from omeprazole to lansoprazole. On 16th August 2019 there was a further telephone appointment with the nurse practitioner, as he still had diarrhoea. He was advised to stop lansoprazole. No face to face appointment or tests were carried out. On 20th August 2019 he was seen by the same nurse practitioner face to face. His temperature was recorded as 35 degrees Celsius, no further observations were recorded. He still had diarrhoea which was worsening. Blood tests subsequently reported on showed poor kidney

	function. He was not seen by a doctor and no stool sample taken. On 21st August he became more unwell and was taken to Salford Royal Foundation Trust. He was acutely unwell and given fluids and a blood transfusion. He was transferred to Trafford General Hospital. He was found to have clostridium difficile which had caused the diarrhoea and pneumonia. He was treated but continued to deteriorate. He died at Trafford General Hospital on 30th August 2019 from multi organ failure due to bronchopneumonia contributed to significantly by his frailty particularly from the clostridium difficile diarrhoea not diagnosed by the GP practice.
5	<u>CORONER'S CONCERNS</u> 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 that Mr Townsend should have seen a GP and had further tests prior to his admission to Salford Royal Hospital. The inquest heard that at the GP practice in question there were insufficient GPs to see patients. In addition there was no evidence of a clear escalation process from the Nurse to a Doctor within the practice. 2. The particular risks he presented with his background health issues were not recognised when he showed signs of being unwell. 3. The quality of the written medical notes at the GP practice was poor. 4. The inquest heard that there had been concerns locally within the area about the GP practice. They were now being acted upon by the CCG but the situation had been an issue for some time before there was intervention.
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 30th July 2020. 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, namely 1) Mrs [redacted] wife of the deceased; 2) Gloucester House Medical Centre, 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	**Alison Mutch** **HM Senior Coroner** **04.06.2020**