REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive,** **Blackpool Teaching Hospital NHS Foundation Trust**
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of 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.
3	**INVESTIGATION and INQUEST** On 10th January 2014 an investigation commenced into the death of Linda Rose Lloyd aged 63 years. The investigation concluded at the end of the inquest heard on 1st April and 28th August 2014. The record of the inquest confirmed as follows: The Medical cause of death was Ia Acute subdural haemorrhage The conclusion of the Coroner as to the death was Narrative conclusion as follows: **Having complained of a headache earlier that morning, on 2nd January 2014 Linda Rose Lloyd was found at her home address at 19:14 hours with a Glasgow coma score of 10/15 and unable to verbally respond to ambulance personnel. She was taken to hospital where she was triaged and assessed as being a very urgent priority. She was not assessed by a doctor until 22:12 hours and noted to have a Glasgow coma score of 7/15. A CT scan was undertaken at 01:15 hours the following morning which confirmed the presence of an acute subdural haemorrhage. She was not felt to be suitable for neurosurgical intervention and was pronounced deceased at 19:55 hours on 3rd January 2014. There was a delay in treatment which could have affected the outcome.**
4	**CIRCUMSTANCES OF THE DEATH** See the contents of section 3 above.

	The inquest was informed that at the time of Mrs. Lloyd's attendance at the hospital her triage assessment was undertaken by a junior paediatric staff nurse, and that these nurses were sometimes utilised to provide cover in the ambulance triage area when staff shortages ensued. Further, that although Mrs. Lloyd was triaged correctly, that the inexperience of the nurse meant that information that the patient was a very urgent priority was not passed on to either the nursing staff for the relevant area or a senior doctor and so was not acted upon as an emergency. The inquest was told by an independent Consultant in Accident and Emergency Medicine that given the patient was suffering from a time critical lesion any delays in assessment, diagnosis and treatment must be regarded as contributory factors to a poor outcome and that certain aspects of her care could and should have been addressed more promptly in terms of: • Medical assessment within 10 minutes of triage; • Initial neurological observations including assessment of pupils and Glasgow Coma Score, plus ongoing regular monitoring of her neurological state starting with every 10 to 15 minutes; • A more immediate response to a history of warfarin use and findings of a raised INR requiring treatment; • CT scanning of the head should have taken place as soon as possible after arrival and certainly within one hour of arrival; • Earlier discussion with the Neurosurgical team. The Consultant further informed the inquest that having triaged the patient and designated her as a "very urgent" priority and then doing nothing about it was completely unacceptable. He added that it is also unacceptable that it was over two hours before Mrs. Lloyd had a second GCS score recorded by an examining doctor and that there was then a further long delay before a GCS score was taken again and recorded on an observation chart. Also, he felt there too long a delay in administering drugs to reverse the effect of warfarin therapy in someone who was actively bleeding. He concluded that it is vital that the Trust undertake a review of this case to address these areas to ensure that any future patients with time critical neurosurgical lesions have prompt assessment, investigation, referral and transfer to optimise the potential for a better outcome.
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. – At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009. • During the Inquiry, I received written evidence a review has taken place further to this incident, and that it is now only the very senior paediatric nurses who are able to triage and that a triage training plan has been implemented which is to be completed by all nurses who triage and is designed to ensure all triage staff are able to assess and direct initial care for patients and ensure they are placed in the most appropriate area post triage. • I was further informed that changes made to departmental policy have incorporated the necessity to consider the effects of patients treated with warfarin, and that A & E consultants are working to improve and implement an

	However, having concluded this inquest, I now write to the Trust to confirm that in my view the Trust should take action because: Although encouraged by the steps being taken, I remain concerned that the procedures in place at the hospital are insufficiently robust, and that staffing levels do not provide the Trust with sufficient resilience, to enable the Trust to minimise the risks of further deaths in similar circumstances particularly given the criticisms made by the independent expert and the number of areas of concern he raises. I would therefore be obliged if the Trust would write to me in due course to confirm what steps if any the Trust proposes to take to address these areas of concern.
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 24th October 2014. 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 family of Linda Rose Lloyd The Coroners Society 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	A.A.Wilson **Alan Wilson** **Senior Coroner for the area of Blackpool & Fylde** **Dated: 29th August 2014**