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:** **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 2nd April 2015 I opened an investigation into the death of Olive Darbyshire. The inquest concluded on 22nd May 2015. The conclusion of the Coroner as to the death was a narrative conclusion as follows: Olive Darbyshire died of natural causes which were more than minimally, trivially or negligibly contributed to by a fall dated 22nd December 2014. The medical cause of death was: Ia Multi Organ Failure Ib Acute intestinal haemorrhage 1c Ischaemic colitis / fracture of left neck of femur following a fall [dated 22.12.14] and dalteparin therapy
4	**CIRCUMSTANCES OF THE DEATH** Olive Darbyshire suffered a fall on 22nd December 2014. She was trying to make her way from her bed to the toilet during the morning of 22nd December 2014 when she became tangled in her bedding and fell suffering a hip fracture. She was taken to hospital. She received dalteparin medication. A Pulmonary embolism was suspected and an urgent CT Pulmonary Angiogram requested on 23rd December to rule out a Pulmonary Embolism. The CTPA re quest was not acted upon. On 26th December 2014 a major intestinal bleed was detected. An endoscopy was carried out but there was no obvious source of the bleed found. Mrs Darbyshire passed away at 14.50 on 28th December 2014. The inquiry learnt that on 24th December the radiology department was provided with information which led to Mrs Darbyshire being erroneously categorised as an outpatient. Despite an attempt later that day to re-classify her as an inpatient, this was not acted upon and she remained categorised as an outpatient the impact of which was that no CTPA was carried out prior to her death.

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. Although it is not possible to say whether a CTPA procedure would have had an impact upon when Mrs Darbyshire died, I am concerned that two senior Doctors gave evidence that they were expecting an urgent CTPA to have taken place and that this had not happened some three days after the request was made. 2. I am concerned that according to the Radiology department there is no record of the clinical team responsible for Mrs Darbyshire's care making efforts to "chase up" the missing CTPA procedure. 3. I am concerned that the radiology department staff have incorrectly categorised Mrs Darbyshire in a way that meant that she spent a number of days in hospital awaiting an urgent CTPA procedure that in reality was not going to happen because once categorised as an outpatient she realistically would only expect to receive a CTPA in 2015 by way of a written notification. 4. I am concerned that given this request was made on 23rd December 2014, subsequent events have been influenced by the fact that the request was made shortly before the Christmas period and that a lack of action taken by the clinical team to "chase up" the CTPA and the actions of the radiology department administration staff have been influenced by reduced staffing levels over the Christmas holiday period when the department would deal with inpatient requests only, and emergency requests pertaining to Accident & Emergency patients.
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 17th July 2015. 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 Olive Darbyshire. 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 Blackpool & The Fylde** **Dated: 22nd May 2015**