# REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**The Chief Executive Officer**<br>**East Lancashire Healthcare NHS Trust**<br>**Trust Headquarters**<br>**The Royal Blackburn Hospital**<br>**Haslingden Road**<br>**Blackburn BB2 3HH** |
| **1** | **CORONER**<br><br>I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley. |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 23rd December 2014 I commenced an Investigation into the death of Jean Helen Hannon aged 75. The investigation concluded at the end of the Inquest which was held on the 23rd September 2015. The conclusion of the Inquest was that Jean Helen Hannon died from a rare but recognised complication of surgical treatment. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 27th August 2011 Jean Hannon who was suffering from altered sensations in her hands due to degenerative changes in her cervical spine underwent a laminectomy at the Royal Preston Hospital. As a consequence of the procedure Jean Hannon became quadriplegic and developed autonomic dysreflexia. Subsequently she had a number of admissions to the Royal Blackburn Hospital but the diagnosis of autonomic dysreflexia was not sufficiently highlighted in the medical record such that when she was admitted to the Royal Blackburn Hospital on the 19th December 2014 with a history of not having opened her bowels for some 13 days the consultant physician [redacted] was unaware of the previous diagnosis of autonomic dysreflexia. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the Inquest the evidence revealed matters giving arise to concern. In my opinion there is a risk that further deaths will occur unless action is |

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| | taken. In the circumstances it is my duty to report to you the **MATTER OF CONCERN** is as follows: -<br><br>That the medical records retained at the Royal Blackburn Hospital failed to sufficiently highlight the previous diagnosis of a condition that is potentially life threatening. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th November 2015. I, the Coroner, may extend this period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following interested person, namely:<br><br>[redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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** | **30 September 2015** **Signed by:** .....<br><br>**H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley** |