REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Officer** **East Lancashire Healthcare NHS Trust** **Trust Headquarters** **The Royal Blackburn Hospital** **Haslingden Road** **Blackburn BB2 3HH**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
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 the 27th of January 2016 I commenced an investigation into the death of David Aughton aged 63 years. The investigation concluded at the end of the Inquest which was concluded on the 11th May 2016. The conclusion of the Inquest was that David Aughton had died from an Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** In August 1999 David Aughton fell and sustained a severe traumatic brain injury which led to epileptic seizures. Those seizures were controlled by lamotrigine and sodium valproate. On the 21st December 2015 he was admitted to the Royal Blackburn Hospital for a cystoscopy which was performed under general anaesthetic. Whilst at the Royal Blackburn Hospital he had not been administered his anticonvulsant medication such that on the 22nd December 2015 he had a grand mal convulsion which caused aspiration pneumonia. Thereafter he remained unwell until he died on the 25th January 2016.
5	**CORONER'S CONCERNS** 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 taken. In the circumstances it is my duty to report to you the **MATTERS OF CONCERN** being as follows: -

	That despite the fact that his regular medications including lamotrigine and sodium valproate were recorded in his medical records, those medications had not been dispensed, leading to a grand mal convulsion it was apparent that there was no mechanism in place to ensure that essential medications were prescribed, dispensed and administered.
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 7th July 2016. I, the Coroner, may extend this 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 person, namely: [redacted] 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	**12 May 2016** **Signed by:** ..... **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**