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:** **Acting Chief Executive** **Blackpool Teaching Hospitals NHS Foundation Trust** Blackpool Victoria Hospital Whinney Heys Rd Blackpool
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 25th April 2018 I concluded an inquest into the death of Catherine Burns, born 03/05/41 and who was reported to have died at Blackpool Victoria Hospital on 05/12/17. The inquest concluded was: NATURAL CAUSES The medical cause of death was: 1 a LOBAR PNEUMONIA

4	**CIRCUMSTANCES OF THE DEATH** Within box 3 of the Record of Inquest the circumstances surrounding this death were summarised as follows: Catherine Burns was admitted to hospital on 4th December 2017 complaining of abdominal pain and at 20.09 hours was triaged as requiring to be seen by a doctor within a period of ten minutes. She was first seen by a doctor no earlier than 1am on 5th December 2017 when it was felt that she was suffering from acute cholecystitis and prescribed intravenous antibiotics which were administered. Initially stable Catherine's condition deteriorated at approximately 10.30 hours later that morning and by 12.50 hours she was observed to be having significant breathing difficulties. She went into respiratory arrest at 13.45 hours and her death was confirmed at 13.48 hours. A subsequent post mortem examination confirmed she had died from the effects of lobar pneumonia which had developed prior to hospital admission. In more detail: This death occurred on 5th December 2017. The Deceased was triaged as requiring an assessment by a doctor within ten minutes but was not seen by a doctor for at least approximately five hours. Although it could not be established that the outcome for her would have been different there is no doubt that the care afforded to her during the hospital admission was affected by the pressure which staff were expected to cope with. The primary reason why she was not seen by a doctor for such a period was due to the number of patients the staff in the Emergency Department had to deal with. I heard evidence from a Year 1 Speciality Trainee working in the Accident & Emergency department who was the doctor who first saw the patient and in his statement to this court he had commented that *"During busy periods, such as this night, there are numerous patients triaged on red, orange, yellow and green throughout the department, it is agreed that patients are seen in time order unless there are specific concerns whereby a doctor, usually a Senior, will be asked to see a patient out of time order. No specific concerns were raised about Mrs Burns prior to her being seen by myself".* However I also received evidence from a Consultant Colorectal & General Surgeon who had been asked to provide an overview of the care afforded within the Emergency Department and he felt that despite the above he would ordinarily expect that even when it may not be possible for a doctor to assess a patient in accordance with the triage assessment [so within ten minutes for Mrs Burns] in which case the patient

	ought to be seen by a member of the nursing staff then the patient should be seen by a doctor within a 30 minute period and he acknowledged that the working conditions were behind the delay in this patient being assessed although he did not feel that any delay ultimately affected the outcome for Mrs Burns. After consultation with the surgical team a decision was taken that she be moved to the Assessment Unit but a bed was not available and she remained in the emergency department. During the morning of the 5th December from 10.30 through to 12.50 there was deterioration in her condition. By 12.50 hours Mrs Burns had deteriorated significantly. Her Daughter alerted the nursing staff. The Consultant on Call for the Emergency Department was alerted, realised the seriousness of her condition, but she arrested shortly afterwards. In my judgement the seriousness of her condition had not been fully appreciated at a time when the staff was so busy. As it transpired an independent pathologist reported that Mrs Burns died from lobar pneumonia which I found had developed prior to hospital admission. Indeed I found that Mrs Burns was likely to succumb to the effects of the pneumonia by the time she was triaged at the hospital.
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: I am concerned that staff were unable to provide the level of care to Catherine Burns that they would have liked to provide or which they felt was appropriate and that that this was due to the number of patients they were expected to care for. Consequently deterioration in her condition was not appreciated as quickly as it may otherwise have been. I am concerned that even during an extremely busy shift for a patient to be triaged as requiring assessment by a doctor and for that patient to then not be seen by a patient for over five hours risks future deaths and especially if the nursing staff are not able to monitor the patient as regularly as they may prefer. When giving consideration to writing a report to prevent future deaths Coroners are not limited to deaths which are felt to have been contributed to by the issue causing

	the Coroner some concern. As stated above the care afforded to Mrs Burns did not in my view alter the outcome for her but this should not prevent this report being written if I believe the duty upon me is met. I received impressive evidence from a Sister whose role was to co-ordinate the assessment area. She explained that during the entirety of the shift the staff had been dealing with approximately one third more patients than when they are performing at what is usually regarded as full capacity. However this was not an isolated incident and this had been the position throughout December, January, and February and that it has remained an issue which is persisting and cannot be solely attributed to what is sometimes described as "winter pressures". It may well come as no surprise that the Emergency Department staff is facing these pressures and it may be that you feel that as a Trust you are doing all that you feel that you can to minimise the impact caused by the increased workload. Indeed I received helpful evidence during the inquest from the co-ordinator of the Emergency Department who explained that efforts have been made to review practices in order to make the system more efficient and hopefully be able to cope with over-capacity. Nevertheless, I believe that I have a duty to write this letter because I feel that there is a risk of future deaths caused or contributed to by staff not having the time to assess and care for patients due to their workloads meaning any potentially significant deterioration in a patient's condition may go unrecognised or is under-appreciated and with serious consequences. 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.
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 June 2018**. 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: Burns family Care Quality Commission 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: 28th April 2018**