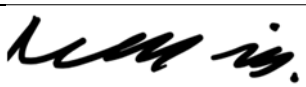
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **Blackpool Victoria Hospital** **Whinney Heys Road** **Blackpool** **FY3 8NR**
1	**CORONER** I am Andrew Cousins Assistant Coroner for **Blackpool & Fylde**.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 27/11/2019 I commenced an investigation into the death of Matthew James Rogers. The investigation concluded at the end of the inquest on 10 December 2019. The inquest determined the medical cause of death was: 1(a) Multiple Organ Dysfunction 1(b) Pneumonia, multiple organ infarctions and ischaemic small and large bowel II Methadone and cocaine, metastatic testicular cancer The conclusion was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Rogers was 31 years old when he was admitted to Blackpool Victoria Hospital on 10 July 2019. Mr Rogers had a previous history of testicular cancer with pulmonary metastases and reported to the Paramedics that he had been suffering from worsening pain for two days with weakness and lethargy. Mr Rogers was noted to be complaining of pain whilst breathing, he had poor peripheral perfusion and his hands were cold, swollen and discoloured. Upon triage at 20:47 on 10 July 2019, Mr Rogers was noted to have a NEWS score of 1. By 03:30 on 11 July 2019, the NEWS score had risen to 6. The NEWS score then increased to 8 at 06.00 and thereafter to a score of 11. There was no record of any observations being taken between 03:30 and 06:00 despite the NEWS score having risen to 6 at 03:30. During this time a plan was made for Mr Rogers to be transferred to the Emergency Room for closer monitoring and review by the Medical Registrar, however the Emergency Room was fully occupied and Mr Rogers was therefore transferred to a more viewable cubicle nearer to the nurse's station. The Medical Registrar was due to assess Mr Rogers on two occasions but on both occasions was called to other emergencies on the wards. Following a Critical Care review, a plan was put in place to treat the low blood sugar of Mr Rogers with oral and IV glucose and further medication was given to correct the patient's electrolytes. A plan for Critical Care was made at 11:30. The patient was found to be in peri-arrest and a 2222 Medical Emergency Call was placed to the Critical Care Team at 12:00 and they attended immediately.

	Transfer was made to the Intensive Care Unit at 14:00 and a CT scan showed extensive organ injury including ischaemia of the liver, spleen and bowel. A DNACPR was completed at 16:20 by the Critical Care Consultant as, in critical illness, CPR was futile. The condition of Mr Rogers deteriorated and he died at Blackpool Victoria Hospital on 11 July 2019 at 22:18.
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. – The Serious Incident Investigation Report set out that the patient's observations were not monitored on an hourly basis in accordance with the Royal College of Physician's guidance for frequency of observations for a patient with a NEWS score of greater than 5. It was noted in the report that Mr Rogers did not have a set of observations recorded for two and a half hours from 03:30 to 06:00. Whilst it was not clear why this omission in care occurred, it was felt likely that this occurred because of understaffing of nurses compounded by the large number of patients within the department. It was reported to me that the nurse staff levels were below template for the night shift. The staffing establishment was for 10 Registered Nurses. At the time in question six substantive Registered Nurses were on duty, plus one agency Emergency Department Registered Nurse. There were no Twilight Nurses or Long Day Registered Nurses. The Serious Incident Investigation Report did not address how these problems were proposed to be resolved by the Trust and what processes were being put in place to address the issue of omission of care arising from understaffing.
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 14 February 2020. 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 next of kin of Mr Matthew James Rogers. 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	20/12/2019

	 Signature Andrew Cousins Assistant Coroner **Blackpool & Fylde**