	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Blackpool Teaching Hospital NHS Foundation Trust** **2) [redacted] Glenroyd Medical Practice**
1	**CORONER** I am Tim Holloway 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 31/10/2018 I commenced an investigation into the death of Frank Raymond STOCKTON. The investigation concluded at the end of the inquest on 27th June 2019. The conclusion of the inquest as to the medical cause of death was: 1a Epistaxis, asbestos related pulmonary fibrosis (treated – oxygen therapy) and ischaemic heart disease (treated – Warfarin) b c II Asbestos related early malignant mesothelioma
4	**CIRCUMSTANCES OF THE DEATH** The following determination as to how, when and where the deceased came by his death and conclusion were reached at the conclusion of the inquest. Mr Stockton was admitted to the Blackpool Victoria Hospital via the Emergency Department on 10th June 2017 with a history of shortness of breath and collapse and with a medical history of pulmonary fibrosis, ischaemic heart disease, atrial fibrillation, calcified pleural plaques and previous myocardial infarction. During the period of his admission and following his transfer to ward 10 he suffered recurring albeit not continuous epistaxis, the extent of which was not identified clinically and thus the epistaxis was not treated at any time prior to his discharge home on 27th June 2018. The epistaxis during the period of that admission was caused by the combined effects of: (a) the use of oxygen therapy and a nasal cannula for the delivery of oxygen which, respectively, had the effects of drying the nasal mucosa and causing irritation to the nose; and (b) the fact that for part of that period of admission Mr Stockton was on Warfarin. In the period between his discharge and his readmission to the Blackpool Victoria Hospital on 20th July 2018 Mr Stockton received non-humidified home oxygen therapy, via a nasal cannula, initially at a flow rate of 4L per minute which was increased to a flow rate of 5L per minute on or about 18th July

	2018. During this period he experienced recurrent epistaxis which was variable in degree and which, again, was occasioned by the combined effects of: (a) the use of oxygen therapy and a nasal cannula for the delivery of oxygen which, respectively, had the effects of drying the nasal mucosa and causing irritation to the nose; and (b) the fact that Mr Stockton was on Warfarin. The nosebleeds were reported to Mr Stockton's GP Practice initially on 28th June 2018, a telephone consultation and a home visit were arranged on 4th July 2018 and epistaxis was diagnosed by his General Practitioner on 13th July 2018. An ENT referral letter was written on a non-urgent basis and had not been sent by the time of Mr Stockton's readmission to hospital. On 20th July 2018 Mr Stockton developed melena and haematemesis and was transferred by ambulance to the Blackpool Victoria Hospital where his condition deteriorated, culminating in his death at 00.45 hours on 22nd July 2018. Mr Stockton's death was caused by the combined effects of: (a) recurrent epistaxis over the period of his first admission (untreated) and following his discharge home; (b) asbestos related pulmonary fibrosis; (c) ischaemic heart disease and was contributed to by the further impact upon his lung function of asbestos related early malignant mesothelioma. Thus his death was contributed to, to more than a minimal, trivial and negligible degree, by: (a) industrial disease (b) a natural cause and (c) the unintended consequences of medical treatment (Warfarin use and oxygen therapy).
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 sole purpose of this report is the statutory purpose. No criticism of the care afforded to the deceased or of any individual clinician is to be inferred from the making of the report. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) It was the evidence of a number of clinicians who gave evidence in the course of the inquest that they had not come across a death occasioned by epistaxis in the course of their clinical careers. In those circumstances the cause of the deceased's death may have been unusual. In that regard he received oxygen therapy both in hospital and, following discharge, at home through a nasal cannula and was also prescribed Warfarin on account of his atrial fibrillation. Whilst, for much of the period in question his Internationalised Normalised Ratio fell within the target range of 2.0 – 3.0 he developed epistaxis which, in the context of and in combination with compromised lung and heart function due to pulmonary fibrosis and ischaemic heart disease, caused his death. In the course of preparing statements for the purpose of the inquest 2 practitioners did not identify and/or did not identify the significance of 2 references to nosebleeds (epistaxis) (or the possibility thereof) within the clinical records. Thus the concern arises that (1) the risks of epistaxis causing or contributing to death, particularly in a patient who is receiving oxygen therapy and/or who is taking Warfarin and/or who has underlying conditions which impair lung and/or heart function and (2) the fact that the risk of death may not be avoided merely on account of the maintenance of a patient's Internationalised Normalised Ratio within a target range may not be known generally amongst clinicians such that circumstances creating a risk of other deaths will occur or will continue to exist in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 1) Blackpool Teaching Hospital NHS Foundation Trust 2) [redacted] Glenroyd Medical Practice have the power to take such action, whether at a local or wider level. This may include (but may not necessarily be limited to) the power to refer the concern to others in a position 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 Friday 23rd August 2019. 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: 1) [redacted] 2) Blackpool Teaching Hospital NHS Foundation Trust 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	27/06/2019 Signature Tim Holloway Assistant Coroner **Blackpool & Fylde**