REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **Will Quince MP**

Minister of State for Health and Secondary Care

Department of Health & Social Care

C/O Ministerial Correspondence and Public Enquiries Unit
Department of Health and Social Care
39 Victoria Street
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Chief Medical Director
Lancashire & South Cumbria Integrated Care Board
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CORONER

I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**

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

INVESTIGATION and INQUEST

The death of **Harold Derek PEDLEY Otherwise known as Derek PEDLEY** on 21.12.22 at Blackpool Victoria Hospital was reported to me and I opened an investigation, which concluded by way of an inquest held on 17th August 2023.

I determined that the medical cause of Mr. Pedley's death was:
1 a Small bowel ischaemia
1 b Severe Superior mesenteric artery atheroma

II Left ventricular hypertrophy; severe coronary artery atheroma

In box 3 of the Record of Inquest I recorded as follows:

Harold Pedley, known as Derek, attended his GP surgery during the late afternoon on 21.12.22 and after spending most of that day feeling unwell with symptoms including abdominal pain and vomiting. He was appropriately referred to the hospital and travelled there with his Friend after his GP had discussed his case with doctors. Due to a lack of available beds in the assessment unit, Derek needed to remain in the emergency department. Following his arrival at 20.07 hours, doctors were not notified of his attendance. He remained in the emergency department waiting area for almost two hours during which time due to significant pressures faced by the department he was not assessed or spoken to by a medical professional. At 21.59 hours a triage nurse called for him. By then, Derek had been unresponsive for some time and had died, his death confirmed at 22.26 hours. A subsequent post mortem examination revealed he died from the effects of non - survivable extensive small bowel ischaemia caused by a significantly narrowed mesenteric artery. His death was contributed to by heart disease.

The conclusion of the Coroner was **Natural causes**

CIRCUMSTANCES OF THE DEATH

In addition to the contents of section 3 above, the following is of note:

- **This inquest was about a man who, aged 90, died whilst waiting to be seen by a medical professional in hospital. He did not simply arrive at hospital, but had been assessed and then sent there by his GP, who felt, rightly as it turned out, that Derek may have developed an obstruction. He was anticipating Derek would be seen quickly.**

- **He arrived at the Emergency Department, and handed in some paperwork at reception and understandably expected he would not have to wait long to be assessed by doctors who he knew were expecting him.**

- **No-one called for him for almost two hours by which time he had died.**

- **It is correct to say that once a post mortem examination was performed, it was clear that even if he had been assessed immediately upon arrival at hospital his condition was such that surgical intervention was not a realistic possibility and the condition was going to prove terminal.**

- **At the time Derek arrived, as the Hospital Trust's own internal review of this death explained, such were the pressures on the hospital Trust posed by patient numbers that it was operating at OPEL [Operations Pressure Escalation Level] 4. This is a method used by the NHS to measure the stress, demands, and pressure a hospital is under. OPEL 4 represents the highest level, when a hospital is "unable to deliver comprehensive care, and patient safety is at risk".**

- **At the time of Derek's death, there was a "Streaming" Nurse working on the Emergency Department whose role it was to undertake initial basic observations and assess the risk of the patients waiting and to prioritise them. However, due to the pressures on the department she was unable to perform that role. Had she had the time to carry out her role as expected, it is likely Derek would have been seen much earlier.**

- **The Emergency Department staff were also under such pressure they did not have the time to notify the doctors who were expecting Derek's arrival at hospital that he had arrived. Those doctors were under similar pressures and had not had the opportunity to check whether Derek had arrived.**

- **Staffing levels had been reduced suddenly for that shift due to staff illness and no additional staff could be made available as a replacement.**

- **Even though a GP had referred Derek on the basis he would not have to spend time in the Emergency Department before being seen on the surgical assessment unit, in reality this was not going to be the case because as the author of the Trust's internal review told the court, due to a lack of beds on the Surgical Assessment Unit, a patient arriving at the Emergency Department such as Derek will almost always have to remain in the Emergency Department for some time waiting for a bed to become available.**

- **The author of the Trust's review, an impressive and candid witness, acknowledged that although on the day on which Derek died was particularly busy, the Emergency Department is regularly subject to these levels of pressure and they are by no means limited to the winter months.**

- **The author also explained how the situation may be eased to some degree were perhaps two surgical beds to remain free for when patients such as Derek arrive in the Emergency Department, but this has not been possible to date.**

- **Finally, it is relevant to point out that Derek had not moved for some time before a medical professional called for Derek. I formed the view that there had been an understandable reluctance on his Friend's part to request assistance due to the pressures staff were clearly under, but also because he had already handed in Derek's paperwork and was expecting some assistance imminently which did not arrive.**

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

- **Concern 1** – that the medical professionals who work in a hospital emergency department are routinely expected to do so when the OPEL 4 applies, a recognition they are performing their roles when the hospital is **"unable to deliver comprehensive care, and patient safety is at risk".** Such pressures may serve to leave the Emergency Department unable to triage patients such as Derek, and have no time to notify the doctors expecting his arrival (in this case doctors on the Surgical Assessment Unit) who are consequently left unaware that a patient has in fact arrived, all of which serves to place vulnerable patients such as Derek Pedley at serious risk.

- **Concern 2 -** that there is a risk that the pressures on hospitals become so significant they are used as a default explanation for levels of patient care that fall below what they would wish to deliver. I found that the hospital Trust did not seek to do so in this case, but it seems to me there is a risk this could happen. The pressures are indeed significant, but ultimately this case involves a 90 year old man with what appears to be an acute medical problem finding himself attending his local emergency department, not being spoken to / triaged by a medical professional for almost two hours, and dying by the time he is called for. There is a clear risk that puts patients at risk and it would be remiss of me not to raise it.

- **Concern 3** - Finally, it is relevant to point out that Derek had not moved for some time before a medical professional called for Derek. I formed the view that there had been a reluctance on his Friend's part to request assistance due to the pressures staff were clearly under, but also because he had already handed in Derek's paperwork and was expecting some assistance imminently which did not arrive. I feel Derek and his Friend thought as they knew doctors had discussed his case with his GP and that his attendance was expected they did not need to raise a concern until it was too late. In actual fact, such are the pressures Emergency Departments are working under, this may not be the case. It is not for me to be prescriptive about what should be done, but unless GPs are provided with a realistic picture about how quickly their patients may be seen once they arrive at hospital (even if they have been in communication with the hospital doctors) their patients may arrive at hospital expecting to be seen quickly, when in reality this may not be the case particularly when the department is under significant pressures.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report. Given the approaching holiday period I have extended this period to Friday 27th **October 2023**. I, the coroner, may extend the period further.

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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

- [redacted] [Daughter of Mr. Pedley]
- [redacted], Medical Director, Blackpool Teaching Hospitals 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.

01/09/2023

Signature 

Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**