REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Medical Director, Blackpool Teaching Hospital NHS Foundation Trust** **(2) Minister of State, Department of Health**
1	**CORONER** I am Louise Rae, Assistant 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. 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** The death of Sabina Wood on 27th January 2023 was reported to Blackpool Coroner's Court and an investigation opened on 7th February 2023 which was concluded by way of an inquest held on 11th and 12th April 2024. I determined that the medical cause of Sabina's death was: **1(a) Acute harmorrhagic pancreatitis** **1(b) Chloelithiasis** The conclusion of the Coroner was that this death was a **Natural Death.**
4	**CIRCUMSTANCES OF THE DEATH** I returned the following in box 3 of the Record of Inquest recorded: Sabina Wood was admitted to the Blackpool Victoria Hospital on 11th January 2023 following complaining of right upper quadrant pain which she had been experiencing intermittently for a few months. A CT scan revealed the presence of gallstones and the possibility of stones in the bile duct. A MRCP scan was performed on 12th January 2023 which showed bile duct stones alongside

	evidence of inflammation of the gallbladder. An ERCP was performed on 23rd January 2023 which did not find gallstones in the bile duct. Sabina discharged herself from the Blackpool Victoria Hospital at 19.40 on 23rd January 2023 against medical advice. She had the capacity to self discharge herself from the hospital. Sabrina contacted North Shore GP Practice on 24th January 2023 complaining of pain in the region where the ERCP was performed and was prescribed oral morphine by the pharmacist following a telephone consultation taking place. Sabrina did indicate any symptoms other than pain and did not tell the pharmacist that she had left the hospital against medical advice. On 25th January 2023 Sabrina contacted the GP Practice and had a telephone consultation with [redacted]. During this consultation she did not describe any new symptoms and said that the morphine prescribed the day before was helping. On 27th January 2023, Sabina's partner found her unresponsive in bed. Paramedics attended and confirmed her death.
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 heard extensive evidence on the practice of preparing hospital discharge summaries over the two days of the inquest. I heard that doctors commonly start to prepare discharge documentation before a patient is ready for discharge. I found that this occurred across disciplines and hospitals given that [redacted] now works at the Royal Preston Hospital as a Consultant where I heard the practice also takes place. The rationale explained to me was that discharge summaries were created early and worked on throughout patient stays. This was to save time and to prevent lengthy summaries being written at the end of long stays for patients. I heard from [redacted], Head of General Internal Medicine at the Blackpool Victoria Hospital that each doctor's practice is different and it is for individual doctors to decide how they create and complete discharge summaries. I found that there is no process or procedure for discharge summaries to be created prior to discharge taking place at the Blackpool Victoria Hospital. In this case, [redacted] created the document on 20th January 2023 before Sabina underwent the ERCP procedure. This document indicated that the patient was discharged on medical advice when in fact she self-discharged against medical advice. The section on ERCP was left blank intending to be completed after the procedure took place and set out that Sabina was well in herself upon discharge with pain settling. As the discharge summary was prepared prior to the ERCP taking place it could not be known whether Sabina was well in herself or that her pain was settling. [redacted] mistakenly clicked on the completed button rather than the save button on 20th January 2023. There is no mechanism for the IT system to double check the document is completed before marking the document as complete. The draft

	discharge summary was sent by staff on 24th January 2023 after Sabina's self-discharge on 23rd January 2023. Staff members believed that it was ready to be sent as it was marked complete by [redacted] [redacted] accepted in her evidence that a draft discharge summary was sent to Sabina's GP Practice in error and told me that her revised practice is that she instructs her junior doctors to mark the discharge summaries as drafts. I heard evidence that Blackpool Teaching Hospital NHS Foundation Trust are undertaking a review which hasn't yet commenced. This will look at the development of a policy of how discharge summaries are prepared. This will also include a review of the IT system with regard to creating and completing discharge summaries. I found it very concerning to hear that speculative information in Sabrina's case was placed on the discharge summary before her procedure took place. There is a risk that this could occur again and in the future this may be significant for a patient's treatment and care. I found that the sending of a draft discharge summary to Sabina's GP Practice by Blackpool Victoria Hospital didn't contribute to Sabina's death. I found that a correctly completed and finalised discharge summary wouldn't have changed the steps taken by [redacted] on 25th January 2023 who was told by the patient that she was improving. It is however, of vital importance that GPs receive timely and accurate discharge summaries from hospitals which may be significant in other cases. For that reason and not withstanding the review or audit that is about to commence at the Blackpool Teaching Hospital NHS Foundation Trust, I consider my duty to prevent future deaths is triggered and that there is a risk to of deaths in the future from this practice which is commonplace and neither medical specialism or hospital specific. I found that these matters gave rise to a risk of future deaths and engaged my duty under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 7th June 2024. 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 family of Sabina Wood [redacted], GP Partner at North Shore Surgery [redacted], Pharmacist at North Shore Surgery A copy of the report will be circulated to the Medical Director of the Royal Preston Hospital and North West Regional Hospitals 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	 **Louise Rae** **Assistant Coroner for Blackpool & Fylde** **Dated: 12 April 2024**