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:** **1. [redacted], Chief Executive East Lancashire Teaching Hospitals**
1	**CORONER** I am Mr Christopher Long, Area Coroner for the coroner area of Lancashire and Blackburn with Darwen
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 23 June 2022 I commenced an investigation into the death of Margaret Clement (92 years old). The investigation concluded at the end of the inquest on 8 May 2024. The conclusion of the inquest was: Margaret CLEMENT died on 15 June 2022 at Royal Blackburn Hospital, Blackburn. Following a fall, Mrs CLEMENT was admitted to hospital where a fractured neck of femur was diagnosed and operated upon on 23 May 2023. Mrs CLEMENT was prescribed anticoagulation following the operation to reduce the risk of clotting. She was discharged to Pendle Community hospital for rehabilitation on 10 June 2022. She had suspected melaena in the evening on 12 June 2022. She then developed significant rectal bleeding in the morning of 14 June 2022 and was admitted to Royal Blackburn Hospital following vomiting blood later in the evening. An upper gastrointestinal bleed was then diagnosed which led to a cerebrovascular accident from which she did not recover
4	**CIRCUMSTANCES OF THE DEATH** Please see box 3 above.
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 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. – (1) Evidence was heard that nursing records on Reedyford ward were inadequate in a number of respects including recording the wrong medication, requesting a medical review for the wrong patient and not recording when an urgent review was needed in the doctor's task book (2)Evidence was heard that nursing handovers were inadequate and did not ensure appropriate risks were managed and prioritised (3)Evidence was heard that doctors on the ward did not effectively prioritise work by

	reviewing the task book in order to identify more urgent tasks (4)Nursing staff failed to request medical review verbally were it was appropriate to do so, relying on a task book. (5) Nursing staff failed to seek urgent clinical assistance when presented with a significant per rectum bleed (6) Inadequate measures have been taken to assess compliance with procedural changes and expectations that have been set following the Trust investigation into this matter
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Wednesday 10 July 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: Margaret Clement's family. 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	 **14 May 2024**