REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO [redacted], Director of Nursing at Lancashire Teaching Hospitals NHS Trust**
1	**CORONER** I am Dr James Adeley, HM Senior 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 March 2023 I commenced an investigation into the death of Marina Sharon Young aged 46 the investigation concluded at the end of the inquest on Friday, 27 September 2024, the conclusion of the inquest was ***Marina Sharon Young died on 22 June 2022 after a 39 hour wait for a hospital bed in Royal Preston Hospital's Accident & Emergency Department. Her death, due to asthma, was preventable and was caused by neglect characterised both by a gross failure to provide appropriate assessment and medical care and an inadequate escalation of her management to specialist physicians or ITU.*** The cause of death was 1a Aspiration b asthma.
4	**CIRCUMSTANCES OF THE DEATH** Marina was born with spina bifida and as a result had decreased sensation from the waist down and reduced motor power in her legs which resulted in the use of an adapted car. Had undergone a bladder transplant as a child and, due to a lack of sensation, needed to self-catheterise every 3-4 hours with a disposable catheter. However, when Marina was unwell, she required assistance with catheterisation, and she was unable to complete the task by herself. Marina also wore incontinence pads. On the morning of 20 June 2024 Marina's chest infection precipitated an asthma attack. Marina was admitted to Royal Preston Hospital Accident & Emergency Department (**A & E**) where she was initially appropriately assessed and treated by the A & E doctor. At this time, the hospital was full and during the remainder of Marina's 39 hour stay A & E had a 'bed block' preventing transfer of patients out of A & E was in place and would have been known to senior nursing staff. Such holding of patients in A & E was described around this time as "continuous". Marina, according to the British Thoracic Society predictive peak flow rates was throughout her stay in A & E in the "life-threatening" asthma category. Marina's asthma attack had an 80% chance of survival but, due to the acute medical team's substantial failures of medical management, inadequate treatment, insufficient direction of the nursing staff for observations and a lack of referral to either respiratory or ITU specialist teams, Marina died at approximately 10 AM on 22 June 2024. During this time Marina's nursing needs were neither assessed nor met, despite it being known to the senior nursing staff that Marina, having complex nursing needs due to her spina bifida, would be spending an extended period of time in the A & E. During Marina's 39 hour stay in A & E none of the six nurses involved with Marina undertook a nursing assessment of

	her toileting needs and failed to offer a catheter, assist with catheterisation or change the incontinence pad. The nursing staff made no assessment of Marina's sensory deficits due to spina bifida and relied upon patient reports for pressure area care in an overweight and incontinent patient, who remained sat in a chair due to her breathing difficulties for almost all of the 39 hours. A falls risk assessment was completed, albeit with substantial errors. When Marina died, she was still wearing the shoes that she was wearing when she arrived in the Department 39 hours earlier and which she could not remove without assistance. It was accepted that A & E is geared up for short-term stays dealing with acutely ill patients. Any patients remaining in A & E beyond the expected period are being nursed in an area that is not designed for their needs, without the benefit of specialist nursing staff and the risks they are exposed to are consequently increased. Despite the Matron for A & E being on the Trust's level 3 STEIS investigation, not a single concern regarding the nursing care provided was identified.
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. When hospital management are aware that, due to hospital capacity issues or other reasons, patients will be spending more than the usual expected time in A & E, A & E managers should be alerted of this perspective status as soon as possible. 2. Any patient remaining in A & E beyond the usual expected time should have an assessment of their care needs. 3. Care needs of patients held in A & E, particularly those with complex care needs, should be identified and managed. 4. Asthma is a common condition. However, A & E lacked nurses with any knowledge of when basic assessment such as peak flow should be taken and no request for assistance from a specialist ward was made. 5. Although the nursing staff made attempts to engage the acute medical team, no attempt was made to escalate problems identified by the treating nurses to senior nursing staff
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 Friday, 29 November 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 and how such action has been audited to ensure any changes are effective. 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 I have also sent it to Care Quality Commission who may find it useful or of interest. 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	 **[DATE]** **[SIGNED BY CORONER]**