	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted],** **Chief Executive,** **Blackpool Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Alan Wilson, senior coroner for the coroner 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. Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths[i] - Courts and Tribunals Judiciary
3	**INVESTIGATION and INQUEST** On 15th July 2024, I commenced an investigation into the death of Brian Kneale, Aged 70 years. The investigation concluded at the end of the inquest on 14th January 2025. The conclusion of the inquest was that Brian died of natural causes. The medical cause of his death was: 1 a **Acute circulatory failure** 1 b **Coronary heart disease, congestive cardiomyopathy and bronchopneumonia complicated by haemorrhagic lung infarct**
4	**CIRCUMSTANCES OF THE DEATH** In paragraph 3 of the Record of Inquest, I recorded as follows: **Brian Kneale was aged 70 years. Reportedly unwell for over a week with evidence of vomiting episodes and worsening shortness of breath, he attended hospital in Blackpool at approximately 3 pm on 27th June 2024. After assessment, concerns were raised he had developed aspiration pneumonia and heart failure. He was placed on the sepsis pathway but did not receive antibiotic therapy until the early hours of the following day. He was felt to be dehydrated and intravenous antibiotics were administered. From the available evidence, the quantity of fluids given is unclear, although**

by the afternoon of 28th June 2024 a portable chest x-ray revealed signs of fluid overload. Given that Brian had heart failure, a kidney injury and was showing signs of infection, the amount of fluids given probably contributed to worsening heart failure. Reviewed by an Intensive Treatment Unit doctor, his prognosis was felt to be poor, and Brain died at 21.45 hours on 29th June 2024 in the presence of his family. A subsequent post mortem examination confirmed he died from the combined effects of heart failure and bronchopneumonia.

The following is of note:

- Upon assessment after arrival at hospital, concerns were raised that Brian was in heart failure.
- During the course of the investigation, his family have raised concerns about the extent of fluids administered during his hospital admission, which had contributed to worsening heart failure.
- Having heard the available evidence, I was in agreement this was probably the case, particularly given that Brian had shown signs of acute kidney injury, and infection.
- Bearing in mind the amount of fluids to be administered in this case required an element of caution, the fluid balance charts had not been recorded appropriately. They did not provide a reliable picture.
- I received helpful evidence from a Consultant in Acute Medicine, who explained that during the Autumn of 2024 he had carried out a piece of work with the aim of improving how fluid balances are monitored and recorded for patients in the Emergency Department, but also the Acute Medical Unit. Notwithstanding he had not worked at the hospital since October 2024, he felt some improvements had been made, but he remained concerned about the position in the Emergency Department, which remained challenging.
- I was left with the impression that clinicians were at times having to make difficult judgements in the interests of patients when they did not have a clear picture about fluid balances.
- Whether a hospital patient has been given an appropriate amount of fluids is a vital element of a patient's care, and when this does not happen effectively for whatever reason, it can understandably cause bereaved relatives significant concern.
- I have a concern that although it seems the hospital Trust is aware there is an issue regarding accurate fluid balance monitoring, the current position is patients remain at risk if decisions may have to be made by clinicians in the absence of accurate fluid balance charts.
- This issue can also have an impact upon reviews conducted internally by a hospital trust, and the extent to which these can be relied upon. The authors of such reviews, in the event appropriate lessons are learned, need to be able to form an accurate impression about the level of care given to patients.

5	**<u>CORONER'S CONCERNS</u>** 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. Fluid balances are not being monitored as effectively as they ought to be;** **2. In the absence of more accurate monitoring of fluid balances, clinicians may find themselves making difficult decisions in the absence of important information;** 3. **Inaccurate recording of fluid balances can leave the authors of internal hospital reviews without the information they require to ensure the correct lessons are learned.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/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 22nd March 2025. 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 Mr Brian Kneale 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	**23rd January 2025**	**Signed:**  **Alan Wilson** **Senior Coroner** **Blackpool & Fylde**