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:** **Blackpool Teaching Hospital NHS Foundation Trust**
1	**CORONER** I am Margaret Taylor, Area 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.
3	**INVESTIGATION and INQUEST** *Conclusion of Investigation (Section 4)* On 25 September 2024 I commenced an investigation into the death of Thomas William OLDCORN. The investigation concluded at the end of the inquest. The conclusion of the inquest was Thomas Oldcorn died as a consequence of a cardiac arrest at the Blackpool Victoria Hospital whilst awaiting delayed Cardiac MRI investigation and coronary artery bypass surgery. The inability to perform surgery within the national standard target contributed to his death. 1a Ischaemic Heart Disease 1b Atherosclerotic Stenosis of the left main Coronary Artery 1c II Hypertension
4	**CIRCUMSTANCES OF THE DEATH** Box 3 of the Record of Inquest recorded as follows: On 1 August 2024 Mr Oldcorn was admitted to Preston Hospital with shortness of breath and chest pains. An ECHO was performed and he was diagnosed with a non ST elevation myocardial infarction. He was transferred to the Blackpool Hospital on 4 September and underwent coronary angiography on 9 September. This revealed severe ostial left main stem disease. He was referred for urgent in - patient surgery. Requests were made for carotid doppler, vein mapping and pulmonary function tests. On 10 September 2024 Mr Oldcorn was reviewed by the consultant cardiac surgeon. A provisional date for surgery of 20 September was allocated which did not meet the national standard which recommends that in - patients awaiting surgery are treated within 7 days of angiography. On 12 September following a cardiac ward round a cardiac MRI was requested. The request was not marked as urgent. On 15 September Mr Oldcorn became tachycardic on 2 occasions. He experienced a further episode of non - sustained ventricular tachycardia on 17 September. The cardiac MRI was chased by the cardiac coordinator who was informed that the radiology team were awaiting information about his pacemaker and the team's ability to be present during the scan. Patients are scanned on Tuesday and Thursday mornings. The next available slot was

	Thursday 19 September. At approximately 06.32 hours on 19 September Mr Oldcorn's heart rhythm on cardiac telemetry went into supraventricular tachycardia and then into ventricular tachycardia . He became unresponsive. CPR was commenced. Defibrillator pads were applied but his heart rhythm was documented to reflect pulseless electrical activity. A decision was made to cease resuscitation attempts. Mr Oldcorn was pronounced deceased on 19 September at 07.34 hours. On the balance of probabilities had it been possible to have operated upon Mr Oldcorn within the national standard target of 7 days he would not have suffered the cardiac arrest and died when he did.
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: (1) I heard evidence during the course of Mr Oldcorn's inquest that despite National targets of 7 days from angiography to surgery at the time of his death the waiting time for surgery was 14 days , that it has since risen to 17 days and that there are inadequate resources to meet the national target.
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 31 July 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 Thomas Oldcorn 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.
9	 **Margaret Taylor**

	Area Coroner for Blackpool & The Fylde **Dated: 5 June 2025**