East Lancashire Hospitals
NHS Trust

Trust HQ
Royal Blackburn Hospital
Haslingden Road
Blackburn
BB2 3HH

Nov 2025

PRIVATE & CONFIDENTIAL

Mr C Long, HM Coroner – via email

Dear Mr Long,

Re: REGULATION 28 REPORT TO PREVENT FUTURE DEATHS – A Studholme

We acknowledge receipt of the Regulation 28 Prevention of Future Deaths report which was issued at the conclusion of the inquest touching the sad death of Adrienne Studholme on the 8th and 9th October 2025.

A senior, core group was coordinated to consider the Trust response to these concerns.

MATTERS OF CONCERN

(1) The fluid balance chart was found to be inaccurate. The evidence suggested that the accuracy of the chart relied on staff collecting and refilling empty water jugs and took no account of steps families may take to provide fluid

(2) Evidence was heard that seizure activity would not be taken into account in assessing a patient in the Emergency Department unless it was witnessed by a member of staff

(3) Evidence was heard that on readmission via the Emergency Department following recent surgery, there is no procedure requiring contact with the original treating department. In addition, there is no standard operating practice and no training ensuring that recent surgery is taken into account in a triage in the Emergency department.

Fluid balance

The Trust acknowledges that fluid monitoring is a recognised national challenge across the NHS. We are committed to addressing this issue locally and have implemented, and continue to develop, measures aimed at improving the accuracy and consistency of fluid balance monitoring within our services.

The Trust has an existing policy in place (copy attached) which outlines the expectation regarding which patients should be monitored on a fluid balance chart. This also describes audit and assurance processes for monitoring compliance. If gaps in compliance are identified, the policy sets out how actions to remedy this are implemented and monitored.

We are currently undertaking a test of change focusing on a more targeted approach, moving from universal charting for every patient, to a risk-based system that prioritises the patients based on clinical need. In specific response to your concern, this new approach includes the engagement of patients and families in accurately recording fluid intake. This is supported by a trial leaflet and recording sheet which enables patients and families to write down what they drink (on their own or via family/friends), whilst they are on or off the clinical departments so these can be matched or added to the fluid balance chart within the patients' records.

Emergency department

With respect to point 2, this concern appears to have arisen from a miscommunication of the evidence provided and reflects neither current nor historic practice within the Emergency Department. Having contacted the consultant who was giving evidence, the point they were trying to convey was that a history of seizures would not warrant immediate escalation to a doctor (either from triage or subsequently). An actively seizing patient would represent a potential medical emergency, or - were it to occur in the department - a potential deterioration in a patient's condition and that this therefore would be immediately escalated when reported from any source.

The third area of concern is that there is currently no process for patient's who present to the Emergency Department following recent surgery to be seen by the original treating department. This is not amenable to a simple procedure – a referral in the context of a problem unrelated to the surgery, where the surgical team may not have expertise related to that condition, would be both futile and add complexity. In this case the initial presentation did not indicate any link with the previous procedure during triage.

It is accepted, however, that where clinical judgement indicates the possibility that a direct surgical complication may have arisen, then urgent contact with the surgical team is essential. Clinicians from the ED have been reminded of the importance of this, and clinicians from the surgical teams of the importance of prompt response. Indeed, a revised version of our internal professional standards for response has been developed, and the Trust commits to monitor these once implemented.

Future assurance monitoring

The test of change regarding fluid balance and the professional standards implementation will continue to be monitored through internal assurance processes, with any escalations to the Quality Committee until all actions have been embedded as business as usual with monitoring processes in place.

Please do not hesitate to contact me with any questions or concern regarding the content of this response; we are keen to work with the Coroner to demonstrate our ongoing commitment to delivering the safest care possible for our patients.

Yours sincerely,

[redacted]

[redacted]
Executive Medical Director
East Lancashire Hospitals NHS Trust

Appendix 1 – Systemic Review of Fluid Balance Monitoring

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Appendix 2 – Clinical Observation Policy

CP37 Clinical Observation Policy [P