REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*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] Executive Medical Director, East Lancashire Hospitals NHS Trust
1	**CORONER** I am Mr Christopher Long , 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 26 March 2024 I commenced an investigation into the death of Adrienne Caroline Studholme, age 62. The investigation concluded at the end of the inquest on 8th and 9th October 2025.The conclusion of the inquest was Adrienne Caroline STUDHOLME died on 23 September 2023 at Royal Blackburn Hospital, Blackburn in Lancashire. Adrienne underwent an elective left nephrectomy on 10 September 2023 complicated by abdominal wall haematoma requiring a further operation on 11 September 2023 before being discharged. She was readmitted on 20 September 2023 at around 3.05 hours with epigastric pain and seizures. Diagnostic checks completed later that afternoon identified spontaneous splenic haemorrhage and rupture (a known complication of nephrectomy) which were operated upon at 18.30 hours, after which she had a myocardial infarction. Despite treatment over the next three days, she did not recover. Her death was contributed to by a delay in diagnosing and treating the splenic rupture. The medical cause of death was found to be: 1a Haemopericardium due to a ruptured acute myocardial infarction 1b Occlusive coronary artery thrombus 1c Coronary artery atheroma, splenic rupture and operation for renal cyst
4	**CIRCUMSTANCES OF THE DEATH** Adrienne Caroline STUDHOLME died on 23 September 2023 at Royal Blackburn Hospital, Blackburn in Lancashire. Adrienne underwent an elective left nephrectomy on 10 September 2023 complicated by abdominal wall haematoma requiring a further operation on 11 September 2023 before being discharged. She was readmitted on 20 September 2023 at around 3.05 hours with epigastric pain and seizures. Diagnostic checks completed later that afternoon identified spontaneous splenic haemorrhage and rupture (a known complication of nephrectomy) which were operated upon at 18.30 hours, after which she had a myocardial infarction. Despite treatment over the next three days, she did not recover. Her death was contributed to by a delay in diagnosing and treating the splenic rupture

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) 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.
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 8 December 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; Family of Adrienne Studholme 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. She 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] 10 October 2025**  **HM Senior Coroner** **Lancashire and Blackburn with Darwen**