


*NOTE: This form is to be used **after** an inquest.*

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. [REDACTED], Chief Medical Officer, Royal Cornwall Hospital</p>
1	<p>CORONER</p> <p>I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 10/11/25, I concluded the inquest into the death of Tracey Oldfield who died in RCHT on 24/10/24 at the age of 56.</p> <p>I recorded the cause of death as:</p> <p>1a) Hypoxic ischaemic encephalopathy and aspiration pneumonia; 1b) Cardiac arrest; 1c) Combined effects of opiate-mediated respiratory depression and an absence of CPAP respiratory support for obstructive sleep apnoea. II) End-stage renal failure complicating insulin-dependent Type 2 Diabetes Mellitus, valvular and hypertensive heart disease.</p> <p>I recorded a conclusion that Tracy died from complications that developed following an elective procedure resulting in an unanticipated admission into hospital.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Tracey was a 56-year-old lady with a diagnosis of type 2 diabetes mellitus, end-stage renal failure, hypertension, obstructive sleep apnoea and peripheral neuropathy. She had been in receipt of dialysis since 2020. She had a surgical fistula to facilitate treatment, but this needed revision.</p> <p>On 17/10/24, Tracey underwent an elective procedure in this regard as a day case which was technically unremarkable. Post-operatively, however, she was found to have low oxygen saturations and low blood sugars. She was admitted.</p> <p>Ordinarily, Tracey slept with CPAP ventilation due to her sleep apnoea.</p>

	<p>She had not brought her device into hospital with her and although documented in her admission records, this was not handed over to ward staff.</p> <p>Additionally, Tracey was not prescribed her normal medications but instead received a standard bundle of medication for surgical patients. This included two doses of oramorph for pain relief where opiate medication was contra-indicated for a patient in end-stage renal failure. The oramorph caused Tracey to become drowsy and unresponsive which was exacerbated by the lack of CPAP ventilation.</p> <p>There was also no senior medical review resulting in a lost opportunity to remedy the oversights.</p> <p>Tracey suffered a cardiac arrest on 19/10/24 and suffered a hypoxic brain injury. She deteriorated and died in Royal Cornwall Hospital on 24/10/24</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of these inquests, the evidence has 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.</p> <p>The MATTERS OF CONCERN have largely been identified and addressed by a Patient Safety Incident Investigation report that was available to the court. A number of changes and improvements have already been made or will be undertaken, for example, when the Trust's IT systems are upgraded.</p> <p>One point that did not appear to have been fully resolved, however, centred on the need for patients who are admitted late and unexpectedly (of which the PSII recorded there are over 1,000 annually) to have their usual medication prescribed in timely fashion.</p> <p>On the facts of this case, Tracey was prescribed insulin when the family informed clinical staff she had a diagnosis of diabetes. Her pain relief was not prescribed at the same time, however, and as she became more uncomfortable after the nerve block used intra-operatively wore off, this resulted in her being prescribed opiates (inappropriately) rather than her usual Gabapentin.</p> <p>There was debate at the inquest as to who would be best placed to prepare the prescription and when. Matron ██████ thought it could be done by an anaesthetist who would be reviewing the patient pre-operatively in any event. ██████ (Head of Patient Safety) felt it could be better done by a junior doctor when a patient was admitted and clerked in. On the facts of this case, Tracey was not seen by a junior doctor (other than to have an insulin prescription) and was not formally clerked in.</p>

6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8 January 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ul style="list-style-type: none"> - Family of Tracey <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>[DATE] 11/11/25</p> <p>[SIGNED BY CORONER] </p>