

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none"> 1. The National Medical Director, NHS England (england.coroners28@nhs.net); 2. The Chief Executive, NHS Wales (dsgdhsceynhswce@gov.wales).
1	<p>CORONER</p> <p>I am David Donald William REID, HM Senior Coroner for Worcestershire.</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> <p>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 22 May 2025 I commenced an investigation and opened an inquest into the death of Lucy Jane PHELAN aged 49. The investigation concluded at the end of the inquest on 30 March 2026. The conclusion of the inquest was that Ms. Phelan "died from complications of having taken prescribed medication with a significant amount of alcohol. Her death was contributed to by neglect."</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 13.5.25 Lucy Phelan, who lived with Emotionally Unstable Personality Disorder which led her on occasion to indulge in impulsive risk-taking behaviour, was found unresponsive at home having vomited after taking various prescribed medications with a significant amount of alcohol. She was taken by ambulance to the Alexandra Hospital, Redditch where she was treated for likely aspiration pneumonia, but later that evening vomited again and soon after that went into cardiopulmonary arrest. Alarms notifying staff at the hospital of her collapse went unheeded for some nine minutes. When an emergency was called, doctors were unable to resuscitate her, and she was confirmed deceased shortly after midnight on 14.5.25.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. -</p> <p>While in the resuscitation bay within the Emergency Department at the Alexandra Hospital, Redditch, Ms. Phelan was attached to equipment which monitored her physical observations. These observations are visible on a screen at the patient's bedside and on a screen at the main nursing station. If a patient's observations rise or fall outside acceptable parameters, the equipment generates both an audible alarm and a visual alarm (red – higher priority; yellow – lower priority) on each monitor.</p> <p>The monitoring equipment has a facility known as "latching" which, if activated, means:</p>

	<p>(a) an alarm will continue to be displayed and sounded even after the conditions which generated it have ended, until it is acknowledged on the monitor, meaning that any alarm for a new or different indication cannot be distinguished audibly; and</p> <p>(b) if the alarm is not acknowledged on the monitor, and the same alarm condition occurs again, this new alarm is not listed in the alarm review or audit log as a new alarm.</p> <p>The inquest heard evidence that "alarm fatigue" is a recognized phenomenon, and that in a busy environment like a hospital's Emergency Department, particularly when patient numbers are high, staff find it increasingly difficult to react and respond to the many different types of alarm in use. The use of the "latching" facility on monitoring equipment is likely to contribute to this phenomenon; this has been recognized by the equipment manufacturer which no longer recommends its use on Emergency Department monitors, and by Worcestershire Acute Hospitals NHS Trust who have switched it off on monitors in its Emergency Departments.</p> <p>It is not known whether, and to what extent, the "latching" facility remains in use in Emergency Departments in other hospitals in England and Wales.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you both have the power to take such action by reviewing the use of the "latching" facility in hospitals in England and Wales.</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 27th May 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 :</p> <p>██████████ (Ms. Phelan's mother); ██████████ (Ms. Phelan's father); ██████████ (Ms. Phelan's sister).</p> <p>I have also sent it to:</p> <p>The Chief Executive, Worcestershire Acute Hospitals NHS Trust</p> <p>who may find it useful or of interest.</p> <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>1st April 2026</p>

David REID
HM Senior Coroner for Worcestershire