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:** **Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust ["the Trust"]**
1	**CORONER** I am Alan Wilson, Senior 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** **The medical cause of death was recorded as follows:** **1 a Multi – organ failure** **1 b Complications following surgery to remove an ovarian mucinous borderline tumour [operated 08/05/18]** **2 Polyarteristis Nodosa and Vasculitis** The conclusion was a Narrative conclusion as follows: **Tina Tait died on 16th June 2018 from complications arising from necessary elective ovarian cystectomy surgery conducted on 8th May 2018. Her death was more than minimally, trivially or negligibly contributed to by her pre-existing co-morbidities.**
4	**CIRCUMSTANCES OF THE DEATH** **On 8th May 2018 Tina Tait underwent an elective and necessary ovarian cystectomy procedure. At high risk of complications the procedure took longer to perform than was anticipated primarily due to the extent of adhesions**

	found. Discharged home on 10th May 2018 Tina was re-admitted to hospital on 13th May 2018 with bleeding from the surgical wound site. On 17th May 2018 a Consultant General Surgeon performed an emergency surgery and a perforation of the mid-transverse colon was identified which had most likely occurred on 8th May 2018 as the surgical wound was being closed. There was then a period of gradual improvement and consideration was given to potential discharge from hospital. However during the course of the 14th June 2018 a deterioration in her condition was not fully appreciated by hospital medical staff and her condition was not escalated to the appropriate level of clinician. Early the next morning her condition continued to decline and she became unresponsive and died at approximately 8pm on 16th June 2018.
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: The concern I have is that there is a risk of future deaths because the opportunity to learn valuable lessons following a death is being compromised by issues pertaining to the quality of record keeping. Issues have arisen in relation to the quality of accessible clinical records [as in this inquest concerning Tina Tait] but also in relation to retention and storage of those records [other investigations – see below] to the extent that the effectiveness of sudden untoward incident reviews conducted by the Trust has been compromised perhaps due to the consequential delay [inevitably leading to lessons being learnt later than they may otherwise have been] or because the quality of the review has been affected [missing documentation leading to internal reviews having to be concluded in the absence of records]. Following Tina Tait's death the hospital trust undertook a sudden untoward incident review. This led to a report being compiled and that document was included in the inquest evidence. One of the authors of that report, [redacted] [redacted] Clinical Matron] gave extremely helpful evidence at the inquest and was an impressive witness. However within the report a learning point was identified namely that the documentation in the case records had been found to be "at times poor and illegible". [Other learning points included the need for improved handover / continuity of care, learning in relation to the recognition of a deteriorating patient and correct use of the Early Warning Score chart with appropriate escalation.] Professionals such as Amanda Langton tasked with investigating deaths clearly need to be provided with all of the necessary information to be able to produce an effective review which ensures the right lessons are learnt

and the risk of future deaths minimised accordingly.

I am concerned that [redacted] having found herself trying to review this matter in the face of poor and illegible records is a reminder that unless this type of issue is not addressed then risks will occur as a consequence. Medical professionals who take over the care of patients from other staff at handover need to be able to familiarise themselves with accessible and legible records. When this does not happen the quality of the care received by patients can be affected. It seems to me that issues persist as regards the quality of record keeping within the Trust and that it would be remiss of me not to raise that concern at this time.

I bear in mind that the quality of record keeping is an issue I have raised with the hospital trust previously. In October 2017 I sent to the Trust a letter of concern written in accordance with paragraph 37 of the Chief Coroner's Guidance No. 5 (Reports to prevent future deaths). That letter was in relation to investigations conducted at this court into the deaths of WB and NM. The letter was felt to be necessary after the inquest into WB's death had to be conducted in the absence of documentation which the Trust was unable to locate. In May 2017 this court received from the Trust a Sudden Untoward Incident Review into the death of NM which had been completed in the absence of some of the hospital records which could not be located.

I was concerned that an improvement in relation to record keeping was essential because having access to quality documentation minimises the chance of, for example, an untoward clinical incident review being delayed or remaining incomplete; it avoids the risk that a coroner's inquest is delayed. Also, and importantly in my view, it is obviously important that records are readily available to assist a coronial inquiry or indeed an internal hospital review not least in order to ensure any lessons which need to be learnt can be learnt and for this to be achieved as effectively as possible an accurate record of events should be available.

In addition to the quality of some of the records relating to Mrs Tait's care in hospital, the Trust's internal review was delayed because the clinical records could not be located for some time resulting in a delay before witness statements could be compiled and the Sudden Untoward Incident Review completed the impact of which was the inquest had to be vacated from the original court slot allocated to it and re-listed.

Other investigations have been affected by similar issues: a further investigation into the death of JS ultimately proceeded in the absence of hospital records which reportedly went missing after the death and could not be found.

In deciding to write this letter I take into account that in response to my letter in October 2017 [see above] I received a response from the Trust dated 4th December 2017 within which the point was made that "it is worth noting that the Trust has somewhere in excess of 500,000 sets of patient records and that

	non-availability is a rare event". The letter went on to helpfully explain that the Executive Directors had approved a business case for the introduction of an electronic document management system which would mean paper records would be immediately accessible to attending clinicians. Unfortunately, having monitored the situation since then I remain concerned that the Trust's procedures in terms of accessibility but also to quality of clinical records poses a risk of future deaths if those procedures are jeopardising the likelihood of the correct lessons arising from a death investigation being learnt. As stated at the conclusion of the inquest, ultimately I did not find that Mrs. Tait's death was caused by or contributed to by the quality of the records or the delay in them being located. However, this does not prevent me from writing this letter if there is a concern future deaths may occur and I write this letter because despite the matter having been raised previously the issue appears to be ongoing as the investigation into Mrs Tait's death illustrates. At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to Blackpool Teaching Hospitals NHS Foundation Trust a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.
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 24th May 2019. 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 of England & Wales and to the following Interested Persons: • Family of Tina Tait • Care Quality Commission 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	A.A.Wilson **Alan Wilson** **Senior Coroner for Blackpool & The Fylde** **Dated: 8th April 2019**