	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST**
1	**CORONER** I am Tim Holloway, Assistant Coroner for **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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16th July 2018 an investigation was commenced into the death of Douglas OWENS. The inquest which formed part of that investigation was opened on 22nd August 2018 and the investigation concluded at the end of the inquest which was heard over a period of 7 days from 28th September 2020 to 2nd October 2020 and on 5th and 7th October 2020. The conclusion of the inquest as to the medical cause of death was as follows: "1a. Acute cardiac failure with hypotension, aspiration pneumonia and multi-organ failure 1b. Coronary artery atherosclerosis with acute metabolic acidosis and with pain occasioned by raised intraocular pressure following cataract surgery and by urinary retention."
4	**CIRCUMSTANCES OF THE DEATH** I reached a narrative conclusion as follows: "On 4th July 2018 Douglas Robert Owens attended the Spire Fylde Coast Hospital for elective cataract surgery in the form of right phacoemulsification and intraocular lens implant. A recognised risk of the surgery eventuated, requiring anterior vitrectomy following which he was given 500mg acetazolamide prior to discharge for the control of intraocular pressure. On the same evening he attended and was admitted to the Emergency Department of Blackpool Victoria Hospital, Whinney Heys Road, Blackpool in the circumstances that he had developed severe eye pain occasioned by retained viscoelastic in the eye and associated pressure and was given a further 500mg acetazolamide orally and 500mg acetazolamide intravenously without his having undergone an ophthalmological examination. The acetazolamide more than minimally contributed to the development of metabolic acidosis and this, together with ongoing eye pain overnight and the development of unalleviated painful urinary retention over a period of hours more than minimally contributed to the development of acute cardiac failure by the morning of 5th July 2018 in the context of his pre-existing coronary artery atherosclerosis and to the development of associated hypotension, aspiration pneumonia and multi-organ failure. He died on the intensive care unit of Blackpool Victoria Hospital at 18.37 hours on 7th July 2018. His death was more than minimally contributed to by neglect."
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. – (1) That Blackpool Victoria Hospital has not yet finalised an agreement with Spire Fylde Coast Hospital for the urgent transfer of patients to the Ophthalmic Unit at Blackpool Victoria Hospital when appropriate. Unless arrangements are formalised, the lives of patients may be put at risk.

	(2) That the Deceased was not seen by a speciality doctor in the Emergency Department notwithstanding the need for him to be seen. Unless action is taken there may be a continuing risk that patients in the Emergency Department will not be seen by on call doctors in speciality disciplines, in particular, ophthalmology, even when the need arises in that Department. (3)That the evidence disclosed omissions in the taking of vital signs observations and in the recording of observations in the vital signs observation chart (incorporating the National Early Warning Score). Unless action is taken, there is a risk that any deterioration in the condition of patients which might put their lives at risk will not be identified at the earliest opportunity. (4)That the evidence disclosed that the review process was not followed upon the Deceased's blood pressure dropping by more than 40mmHg, notwithstanding the fact that that observation had been recorded. Unless action is taken, there is a risk that any deterioration in the condition of patients which might put their lives at risk will not be reviewed at the earliest opportunity. (5)That the evidence disclosed the fact that, whilst fluids had been prescribed, no prescription chart or fluid balance chart had been completed. Unless action is taken to ensure the completion of applicable documentation, the lives of patients may be put at risk. (6)That the evidence disclosed the fact that the Once-only and Pre-medication Chart does not make provision for the dose of medication actually given to be recorded *in the event that* the dose prescribed has been specified as falling within a range (for example, as here, morphine 1-10mg) and that, in any event, the actual dose given was not recorded in that chart. Unless the giving of medication is recorded fully the lives of patients may be put at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Blackpool Teaching Hospital NHS Foundation Trust, 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 14th December 2020. 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: • **THE FAMILY OF MR DOUGLAS OWENS** • **SPIRE FYLDE COAST HOSPITAL** • **MR [redacted], CONSULTANT OPHTHALMIC SURGEON** 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	19/10/2020 Signature *TRHolloway* Tim Holloway Assistant Coroner **Blackpool & Fylde**