Regulation 28: Prevention of Future Deaths report

Chimezie DANIELS (died 26.01.21)

	THIS REPORT IS BEING SENT TO: **1.** [redacted] **Head of Patient Safety** **NHS England & NHS improvement** **PO Box 16738** **Redditch B97 9PT** [redacted] **2. Medicines and Healthcare products Regulatory Agency** **10 S Colonnade** **London E14 4PU** [redacted]
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 15 February 2021, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Chimezie Daniels, aged 60 years. The investigation concluded at the end of the inquest on 15 June 2021. I apologise most sincerely for the delay in sending this report. I have had some difficulty in identifying the correct recipients. I made a narrative determination at inquest, which I attach.

4	**CIRCUMSTANCES OF THE DEATH** Mr Daniels' medical cause of death was: 1a SARS CoV-2 infection 2 pulmonary sarcoidosis
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. At inquest, I heard that on most CPAP machines, the alarm that sounds for a very small leak from the mask is no different from the alarm that sounds for total cessation in oxygen supply. Clinicians told me that it would be much more helpful if very serious matters were denoted by an urgent alarm, and less serious matters in another way. When the alarm on Mr Daniels' machine sounded, there were four other alarms sounding simultaneously for the four other patients in the bay where he was being nursed. This gave the determination of the cause of his low oxygen saturations an added complexity, particularly at a time in the pandemic when there was so much pressure on beds that CPAP patients were being nursed on medical wards rather than in the high dependency unit. I appreciate that there will not always be an intention to connect to an oxygen supply. Nevertheless, I am sure that further consideration can be given to the issue that the inquest touching Mr Daniels' death has highlighted.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 20 September 2021. 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 following. • [redacted], wife of Chimezie Daniels • [redacted], Homerton University Hospital • British Thoracic Society • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 16.07.21 *ME Hassell*