IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Sheldon Marshall
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** Mr [redacted] Founder and Managing Director of the Mayday Group Unit 1 Clifton Mews Clifton Hill Brighton BN1 3HR
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An investigation into the death of **Sheldon Marshall** was commenced on 10 January 2018 and an inquest into his death was opened on 5 February 2018. The inquest was resumed on 30 June 2021 and concluded on 16 July 2021. The medical cause of Mr Marshall's death was: 1a. Cardio-Respiratory Arrest 1b. Bronchopneumonia with Adult Respiratory Distress Syndrome and Pneumothoraces (treated by chest drains) AND Right Haemothorax resulting from a Pleural Injury caused by the right chest drain 1c. High Altitude Induced Pulmonary Oedema AND Fracture of Left Rib 2. Left Ventricular Hypertrophy

	The inquest concluded with a narrative conclusion, which is set out below.
5	**CIRCUMSTANCES OF THE DEATH** On 4 November 2017 Mr Marshall arrived in Kathmandu, Nepal to participate in a group trek to Mount Everest Base Camp. On the morning of 5 November 2017 the group flew to Lukla and began their trek. During the period from 5–10 November Mr Marshall participated in the trek without raising any particular concerns, albeit he walked at a slower pace than the rest of the group. On 11 November 2017, however, Mr Marshall found the trek difficult and walked behind the rest of the group accompanied by an Assistant Guide. At Dukla Mr Marshall hired a horse to enable him to continue to Lobuche, which was the next destination on the trek. However, after about fifteen to twenty minutes on the horse the saddle buckle broke and Mr Marshall fell off sustaining a left rib fracture. Following Mr Marshall's arrival at Lobuche it was decided that it was not suitable for him to continue the trek and it was arranged that Mr Marshall would fly off the mountain the following day. Later than night Mr Marshall began to show signs of suffering from High Altitude Pulmomary Oedema (HAPE). On 12 November 2017, Mr Marshall was admitted to the CIWEC Hospital in Kathmandu where he was diagnosed with HAPE, a fractured left rib and subsequently diagnosed with fungal pneumonia. Following his admission to the hospital his condition he did not respond to treatment and he deteriorated significantly.

	By 28 November 2017 he met the criteria for Severe Acute Respiratory Distress Syndrome (ARDS) and on the same day he was intubated and begun on mechanical ventilation. On 6 December 2017 Mr Marshall was transferred by Air Ambulance from the CIEWC Hospital in Kathmandu to the Indraprastha Apollo Hospital in New Delhi. On 7 December 2017 Mr Marshall was diagnosed with a left sided pneumothorax and on 12 December 2017 he was diagnosed with a right sided pneumothorax, as a result of which chest drains were inserted. The pneumothoraces were in part due to his underlying condition and in part to his ongoing mechanical ventilation. On 16 December 2017 an attempt was made to repatriate Mr Marshall to the UK on compassionate grounds, albeit by this stage he was critically ill and his death was inevitable whether he remained in New Delhi or returned to the UK. At some point following Mr Marshall's departure from the Indraprastha Apollo Hospital in New Delhi on 16 December 2017, and prior to the clinical assessment undertaken at the airport by the Air Ambulance team, Mr Marshall sustained a pleural injury due to the presence of the right chest drain, which resulted in active bleeding from the chest drain. The exact mechanism of how the injury occurred is not known. As a result of the injury Mr Marshall's already critical condition deteriorated further and the Air Ambulance team advised that he be returned to the Indraprastha Apollo Hospital. During the return journey Mr Marshall sustained a cardiac arrest and was resuscitated before being readmitted to the Intensive Care Unit at the Indraprastha Apollo Hospital. On 17 December 2017 he sustained a further cardiac arrest and died in the Intensive Care Unit of the Indraprastha Apollo Hospital. His death was due to a combination of HAPE and a fractured left rib which led to Bronchopneumonia with ARDS and related pneumothoraces.

	His death was hastened by the pleural injury sustained on 16 December 2017 and contributed to by his underlying condition of Left Ventricular Hypertrophy.

6	**CORONER'S CONCERNS** During the course of the inquest the court heard evidence that: Mr Marshall booked his trek with a company called Exodus Travels Limited. Prior to travelling he bought an insurance policy which included cover for emergency repatriation and air ambulance charges. The court heard that Mr Marshall bought the policy through Exodus Travels Limited with the ultimate insurer being Inter-Partner Assistance SA (IPA), a company based in Belgium. Global Benefits Europe BV (GBE) was responsible for selling IPA's insurance policies and managing any related claims. GBE had contracted with Mayday Assistance Limited to provide overseas medical assistance to policy holders such as Mr Marshall. **Senior clinical input at Mayday Assistance Limited** At the conclusion of the inquest the court found that there was an omission on the part of Mayday Assistance Limited to ensure that their Medical Director was aware of, and providing clinical leadership in relation to, Mr Marshall, from at least 22 November 2017. Whilst the court was not persuaded that this omission caused or contributed to the particular facts of Mr Marshall's death, the Coroner is concerned that the level of senior clinical input at Mayday Assistance Limited remains insufficient and may have a negative impact on the medical management of current and future policy holders and therefore presents a risk of future deaths. **The medical management of patients once Mayday Assistance Limited has instructed an Air Ambulance provider** During the course of the inquest the court heard evidence that on 24 November 2017 Mayday Assistance Limited instructed Tyrol Air Ambulance (TAA) to repatriate Mr Marshall from Nepal to the UK. The court heard that the repatriation to the UK did not ultimately go ahead as Mr Marshall was not considered fit enough to undergo the flight on the dates that TAA had an available aircraft. The court found that during the period from 24 November to 4 December 2017 there was a lack of clarity as between Mayday Assistance Limited and TAA with regards to who was responsible for Mr Marshall's overall

	medical management, and as a result neither Mayday Assistance Limited nor TAA were monitoring Mr Marshall's ongoing condition with a view to reviewing and advising on (i) whether the UK was the appropriate destination for Mr Marshall and identifying potential regional alternatives and (ii) the overall risk/benefits of him remaining in Nepal versus being transferred to another country in the region. Whilst the court was not persuaded that this omission caused or contributed to the particular facts of Mr Marshall's death, the Coroner is concerned that this lack of clarity remains today, not only as between Mayday Assistance Limited and TAA but potentially as between Mayday Assistance Limited and other air ambulance providers, which presents a risk of future death. The **MATTER OF CONCERN** is: 1. The Coroner is concerned that the level of senior clinical input at Mayday Assistance Limited is insufficient and considers that this may have a negative impact on the medical management of current and future policy holders and therefore presents a risk of future deaths. Mayday Assistance Limited is invited to consider whether the current level of senior clinical input is sufficient. 2. The Coroner is concerned that there is a lack of clarity as between Mayday Assistance Limited and the air ambulance providers they instruct with regards to their relative responsibilities for the overall medical management of patients and considers that this presents a risk that such patients may not be effectively and comprehensively managed and as such presents a risk of future death. Mayday Assistance Limited is invited to take steps to clarify the position with all the air ambulance providers they instruct.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Marshall's family 3. Exodus Travels Ltd 4. Capital Air Ambulance 5. Global Benefits Europe BV 6. Tyrol Air Ambulance 7. European Aero Medical Institute (EURAMI)
10	**Signed:** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 20th day of August 2021**