Signed by Geoffrey Sullivan
Title Senior Coroner
Jurisdiction Hertfordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive East & North Hertfordshire NHS Trust.
1	**CORONER** I am Geoffrey Sullivan HM Senior Coroner for Hertfordshire
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 the 5th January 2020 David Clark died at the Lister Hospital and on the 10 January 2020 I commenced an investigation into his death. The investigation concluded by way of an inquest on 13 January 2022, which found: Cause of Death: 1a Type 2 Respiratory Failure 1b Pneumonia 1c Chronic Obstructive Pulmonary Disease II Severe Ankylosing Spondylosis, Ischaemic Heart Disease and Fatty Liver Narrative Conclusion: David Clark was admitted to Lister hospital on 21 November 2019 following a fall and injury to his spine. He had a background of Ankylosing Spondylosis, severe Kyphoscoliosis, Chronic Obstructive Pulmonary Disease, was on long term home oxygen and used a non-invasive ventilator (NIV) machine at night. He was transferred to Addenbrookes hospital but found not suitable for surgical intervention and transferred back to Lister hospital and then discharged to Queen Victoria Memorial on 21 December 2019 for rehabilitation. He was re-admitted to Lister hospital on 3 January 2020 drowsy and in respiratory failure. No Respiratory Support Unit (RSU) bed was available on the 4 January 2020. On the afternoon of the 5 January 2020 a bed was made available on ward 11a, close to the RSU, and he was transferred but on arrival he was found to be deceased. During his stay at Queen Victoria Memorial hospital he was unable to use his NIV machine as intended. When he returned to the Lister hospital his NIV machine was not moved with him and had to be collected by members of the family. His worsening condition was not accurately assessed, and his treatment was not appropriately escalated. It is not clear, however, whether these matters contributed to his death.

4	**CIRCUMSTANCES OF THE DEATH** During the inquest I heard evidence from a number of medical witnesses: Dr [redacted], pathologist; Dr [redacted], Medical Director QVMH; [redacted], Cons. Neurosurgeon; Prof, [redacted] Cons. Respiratory Physician; Dr [redacted], Cons. ICU; Dr [redacted] provided an RCA report. From the evidence, a number of failings were identified in relation to the care received by Mr Clark. As outlined above, it is not clear whether they contributed to his death, but they present a wider concern for the provision of future care. Despite being significantly unwell on his return to Lister hospital on the 3rd February 2020 his care was not escalated in a timely fashion. Consultant review only took place 24 hours after his admission. I heard that, at the time, there was a full complement of staff. The evidence suggests that NEWS, a fundamental aspect of patient care, were not being calculated or recorded accurately. Mr Clark's treatment and course through the hospital was poorly documented. Poor documentation makes treatment by following clinicians difficult and also investigation following a death or adverse event more difficult.
5	**<u>CORONER'S CONCERNS</u>** 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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) That care was not escalated appropriately in ICU despite being fully staffed. (2) That NEWS were not being calculated or documented accurately. (3) That documentation, more generally, was poorly completed.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] as Chief Executive 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 12th April 2022. 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 David Clark. 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	15th February 2022 Signature  Geoffrey Sullivan HM Senior Coroner for Hertfordshire