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

The Inquest Touching the Death of Richard Scott-Powell
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** Dr [redacted] Chief Executive Holy Cross Hospital Haslemere Surrey GU27 1NQ
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 inquest into the death of **Richard Scott-Powell** was opened on 4 March 2021. The inquest was resumed on 6 April 2022 and concluded on 7 April 2022. The medical cause of Mr Scott-Powell's death was: 1a. Covid 19 Pneumonia 2. Spinal Cord Injury due to a fall on 19 March 2020, Previous Stroke The inquest concluded with a narrative conclusion as set out below.

5	**CIRCUMSTANCES OF THE DEATH** The inquest concluded with a narrative conclusion as follows: Mr Scott-Powell was 61 years old and had a past medical history which included a previous stroke. On 19 March 2020 he suffered a fall at his home address. It has not been possible to establish how the fall occurred. As a result of the fall Mr Scott-Powell sustained a spinal cord injury, as a result of which he was tetraplegic. He was treated initially at East Surrey Hospital where he underwent a tracheostomy and was cared for on a ventilator in the Intensive Care Unit. On 18 July 2020 he was transferred to the Lane Fox Unit in London where his tracheostomy was converted to a mini-tracheostomy and he was weaned from the ventilator. On 4 January 2021 Mr Scott-Powell was admitted to the Holy Cross Hospital in Haslemere, Surrey for nursing care and long-term neurorehabilitation. On 6 January 2021, he was noted to have developed a temperature and on 7 January 2021 he had a negative COVID-19 test before testing positive for COVID-19 on 11 January 2021. It has not been possible to establish when or how Mr Scott-Powell contracted COVID-19. Mr Scott-Powell died at the Holy Cross Hospital in Haslemere on 18 January 2021. His death was caused by COVID-19 Pneumonia and contributed to by his pre-existing spinal cord injury and his previous stroke. The spinal cord injury and the stroke contributed to his death by making him more

	susceptible to developing COVID-19 pneumonia and compromising his ability to recover thereafter.

6	**CORONER'S CONCERNS** The court heard evidence that following Mr Scott-Powell's positive COVID-19 test on 11 January 2021 a NEWS2 Observation Chart was commenced on 13 January 2021. On that day he initially had a NEWS2 score of 10 and subsequently a NEWS2 score of 5. There is no clear evidence in the hospital records to show that these scores prompted an increased level of frequency of observations or that they were escalated, whether that be to Mr Scott-Powell's GP or otherwise. Thereafter, there are no further NEWS2 charts in Mr Scott-Powell's records, albeit some of his vital signs are recorded in the daily notes. On a number of occasions, the notes only record that 'vital signs are okay' without specifying what the vital signs actually were. In respect of some of the vital signs that were recorded, Dr [redacted], a GP at Grayshott Surgery which is the GP Surgery for patients at Holy Cross Hospital, gave evidence that some of them fell outside normal or expected parameters. Again, there is no evidence in the notes to show that these observations were escalated prior to Mr Scott-Powell's death. Given Mr Scott-Powell's pre-existing conditions and vulnerabilities the Court was not persuaded, on the balance of probabilities, that any escalation would have resulted in treatment, which would have materially improved Mr Scott-Powell's clinical progress. The **MATTER OF CONCERN** is: 1. There is no recorded escalation of Mr Scott-Powell's NEWS2 scores on 13 January 2021;

	2. During the period from 14 January 2021 onwards, only some of his vital signs are recorded, some of which fall outside normal parameters. There is no recorded escalation of these observations in the record. 3. During the period from 14 January 2021 onwards, a number of entries record that his vital signs were okay without detailing the actual outcome of those observations. The Coroner is concerned this may not be a safe practice in that it makes it difficult for the clinical team to track progress and identify any trends. Dr [redacted], a Consultant in Rehabilitation Medicine at Holy Cross Hospital and Dr [redacted], GP, both attended Court to give evidence and whilst they did their best to assist the Court on these matters, it remains unclear to the Court as to whether there are sufficient and appropriate policies are in place, which are well understood by the staff, in relation to the taking, recording and escalation of vital observations at Holy Cross Hospital. Accordingly, the Coroner considers that a review of these matters should be carried out to identify whether additional policies/procedures and or/training is required.
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 Scott-Powell's family 3. Surrey and Sussex Healthcare NHS Trust 4. South East Coast Ambulance Service 5. Medi4 Ambulance Services
10	**Signed:** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 19th day of April 2022**