ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mid Yorkshire Hospitals NHS Trust**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (E).
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.
3	**INVESTIGATION and INQUEST** On 23/04/20 I commenced an investigation into the death of Leslie Clewarth aged 86. The investigation concluded at the end of the Inquest on 06/11/20. The Inquest reached a narrative conclusion to the effect that Leslie Clewarth died in hospital from natural causes: 1a. aspiration pneumonia, 1b. small bowel obstruction 1c. adhesions within the peritoneal cavity and II. ischaemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** The family of Mr Clewarth were called before 7am on 07/04/20 due to the deterioration in his condition. They were permitted to remain at his bedside throughout the day, notwithstanding the COVID19 visiting restrictions then in force. Concerns were raised by his daughter and her husband in relation to: (1) The NG tube previously inserted was no longer in place. (2) The syringe driver was empty at some point after 4pm that day. In consequence, he was deprived of essential medication and hence died in agony after choking on faecal material aspirated. (3) After he had died an injection of Buscopan was made. (4) He had not been treated for a severe coronary condition despite being in hospital for many weeks. Medical records which should have documented these matters were missing or inadequate.
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) Without adequate records showing the care provided or dosage administered, it was not possible to corroborate the testimony of nurses who had attended to Mr Clewarth on the afternoon he died. This fuelled the suspicions raised by his daughter and her husband. (2) Drugs which were left unused after Mr Clewarth's death were not accounted for. Without proper records there is a risk that essential care may not be provided or is erroneously duplicated, thus potentially putting a patient's safety or health at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 15 January 2021. I have extended this period on account of the ongoing COVID crisis and the forthcoming holidays. 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 [redacted] 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	**10th November 2020** Kevin McLoughlin Snr. Coroner