# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

**REGULATION 28 REPORT TO PREVENT DEATHS**

**THIS REPORT IS BEING SENT TO:**

**The Chief Executive**
**Queen Elizabeth Hospital**
**Gayton Road**
**King's Lynn**
**Norfolk**
**PE30 4ET**

**1 CORONER**

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

**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 19/06/2018 I commenced an investigation into the death of Peter David KNIGHT aged 70. The investigation concluded at the end of the inquest on 15/01/2019. The conclusion of the inquest was: Accident.

The medical cause of death was:

1a Acute Exacerbation of Idiopathic Pulmonary Fibrosis
1b
1c

II Ischaemic Heart Disease

**4 CIRCUMSTANCES OF THE DEATH**

Mr Knight had a long-standing history of idiopathic pulmonary fibrosis and was oxygen dependent. He was admitted to the Queen Elizabeth Hospital on 5 June 2018 and was diagnosed with a chest infection. On 6 June 2018 Mr Knight was transferred from the Medical Assessment Unit to Necton Ward during which time he was not connected to portable cylinder oxygen. On arrival on the ward he was seen to be hypoxic and despite being given oxygen, Mr Knight died later that evening.

**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 the inquest I was satisfied that the Trust took the concerns raised seriously and was in the process of reviewing its Policy with regard to the transfer of patients, particularly those who are oxygen dependant. It was anticipated the Policy would be completed by the end of February 2019. In the circumstances, I wrote to the Trust asking them to write to me by 15 March 2019 with full details of the Policy. Not having heard from the Trust, my Officer contacted the Trust today. A response has been received indicating that new documentation has now been generated but a trial into its use has not yet commenced. Although it is stated that a trial is due to be started within the week and that if effective, implementation will be ratified by end of April, I am concerned that the inquest concluded in January 2019 and the Policy was not completed in the timescale indicated and agreed at the inquest and its trial has not yet commenced.

**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 13 May 2019. 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:

[redacted]
Clinical Commissioning Group
Department of Health
CQC
HSIB
Healthwatch in Norfolk

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 Dated: 18/03/2019**

**Jacqueline LAKE**
**Senior Coroner for Norfolk**
**Norfolk Coroner Service**
**Carrow House**
**301 King Street**
**Norwich NR1 2TN**