Regulation 28: Prevention of Future Deaths report

Moses Victor Boardman (died 27/12/19)

	THIS REPORT IS BEING SENT TO: 1. Barts Health NHS Trust 2. London Borough of Tower Hamlets 3. Three Sisters Care Ltd
1	**CORONER** I am: Graeme Irvine. HM Assistant Coroner for Inner London North, Poplar Coroners Court, 127 Poplar High St, Poplar, London E14 0AE
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 2nd January 2020, HM Senior Coroner Mary Hassell commenced an investigation into the death of Moses Victor Boardman, The investigation concluded at the end of the inquest on 11th August 2020. I made a determination of Accidental Death. The medical cause of death was: 1a Aspiration Pneumonia, 1.b Cerebrovascular Accident.
4	**CIRCUMSTANCES OF THE DEATH** Mr Boardman was an elderly and frail man who experienced a decline in his health in late 2019. Following a period of inpatient care at the Royal London Hospital ("RLH"), the London Borough of Tower Hamlets ("LBTH") assessed his care need to require a placement in sheltered accommodation with 4 x daily domiciliary care. On the 17th December 2019 Mr Boardman was mistakenly discharged to his home address by RLH. The error was discovered by LBTH on 18th December 2019 who learned that Mr Boardman had not arrived at his sheltered accommodation.

	LBTH immediately contacted the RLH who could not assist with Mr Boardman's whereabouts as no note had been made by the discharge note regarding where he had been taken. LBTH located the patient at his home address, the address had no heating, light or food. Mr Boardman was taken to his sheltered accommodation where he was assessed to have deteriorated. The patient was was readmitted to hospital where it was discovered he had suffered a further Cerebrovascular Accident ("CVA"). Whilst in RLH Mr Boardman was assessed for risk of aspiration, he was determined to be at risk and accordingly he was to be fed at risk, requiring soft food, in small pieces, whilst supervised. On the evening of 26th December 2019 was found in his room eating a whole fruit whilst unsupervised. The fruit had not been provided to him by the hospital, a quantity of fruit on his bed table was removed from his bedside. In the early hours of 27th December 2019 Mr Boardman was found to have experienced a choking incident, suction was utilised to remove aspirate. A witness indicated that a piece of fruit was found in the aspirate, other witnesses indicated this was not the case. As a DNACPR order was in place no attempt to commerce CPR was made by staff. Mr Boardman died at 04.48.
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. The absence of a clear computerised record in the RLH departure lounge explaining the change of address. 2. The lack of a clear safeguard to ensure that a vulnerable patient is discharged to the correct address. 3. The failure of RLH transport staff to properly assess the suitability of the venue that a patient is being taken to. 4. The responsiveness of the care provider commissioned by LBTH to escalate the fact that they had been unable to reach Mr Boardman for his first 3 care visits. 5. The proper monitoring of patients on RLH ward 14F who have been assessed as being "fed at risk". Specifically, why was a vulnerable patient left with unsuitable foods within his reach.

	6. The RLH failure to commence CPR when a potential reversible cause for collapse existed that would override the effect of the DNAR order.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 6th October 2020 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 following. • Mr Boardman's next of kin. • The Nursing and Midwifery Council. • The Secretary of State for the Department of Health. 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	**DATE 11th August 2020** **SIGNED BY ASSISTANT CORONER IRVINE**