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

The Inquest Touching the Death of Volodymyr KOROL
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted], Director and Umbreen Tressy David, Director Whitepost Healthcare Group Sterling House 27 Hatchlands Road Redhill Surrey RH1 6RW
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** The inquest into the death of Volodymyr KOROL was opened on 20 August 2020. It was resumed with a jury on 21 March 2022 and the conclusion was handed down on 30 March 2022. The medical cause of Mr Korol's death was: 1a. Fatal Ventricular Arrythmia 1b. Left Ventricular Hypertrophy and Ischemic Cardiomyopathy 1c. Morbid Obesity, Diabetes Mellitus, Hypercholesterolaemia, Hypertension, Obstructive Sleep Apnoea 2. Paranoid Schizophrenia/Schizo-Affective Disorder

	The inquest concluded with a short form conclusion of 'natural causes' and a narrative conclusion as set out below.
5	CIRCUMSTANCES OF THE DEATH The inquest concluded with the following findings as to where, when, how (meaning by what means and in what circumstances) Mr Korol came by his death and conclusions: **Paragraph 3 of the Record of inquest** Volodymyr Korol arrived in the UK from Ukraine with his mother in 2002 when he was 17 years old. In 2003 Volodymyr was diagnosed with depression. On 23 July 2015, Volodymyr was detained under section 3 of the Mental Health Act 1983 and admitted to Shrewsbury Court Independent Hospital with a diagnosis of paranoid schizophrenia/schizo affective disorder. From 3 August 2015, Volodymyr Korol was registered as a patient with Holmhurst Medical Centre who provided their GP services to Shrewsbury Court Independent Hospital as a service level agreement was in place. Volodymyr had a history of fluctuating compliance in regards to his medical conditions and related treatments. Volodymyr was diagnosed with the following medical conditions:- morbid obesity, diabetes mellitus and hypercholesterolaemia. Volodymyr also suffered with hypertension, left ventricular hypertrophy, ischaemic cardiomyopathy and obstructive sleep apnoea. During the events of 30 July, 31 July and 1 August 2020, Volodymyr was on level 2 observations which required a check to his physical health every 10-15 minutes. In addition, Volodymyr's vital signs were monitored using a MEWS chart (Modified Early Warning System) and these were instructed to be taken twice a day.

On 30 July 2020, a MEWS entry was made at 10.08, evidencing Volodymyr's SP02 levels (oxygen saturation) as 81-89%, both of which fall into the red category of the MEWS chart requiring immediate medical action. On 31 July 2020, two vital signs were logged on the MEWS chart: neuro and temperature. Volodymr refused his vital signs to be taken at 20:15.

The nurses notes taken on 31 July 2020 at 03.16 indicates that Volodymyr's vital signs were taken and an SP02 reading of 82% was documented indicating immediate medical action required based on the MEWS recommendations. There was no subsequent action recorded or taken.

The following is a precis of events on 31 July 2020 and 1 August 2020:
(PLEASE NOTE: the following indicated times are based on CCTV timestamp, which are known to be inaccurate.)

: at 20:26 Volodymyr retired to his room. Between the hours of 21.07 and 00:01 a staff member checked Volodymyr's room on four occasions.

: the next time Volodymyr's physical health was checked was at 03.14:23 when a staff member entered Volodymyr's room and left the room at 03:14:59. Volodymyr was found unresponsive and not breathing.

(PLEASE NOTE: the following are times are accurate)

: following the discovery of Volodymyr, a staff member telephoned a registered nurse in charge of a neighbouring ward for assistance and telephoned 999 at 03:00:41.

: a subsequent 999 call was received.

:at 3:10 paramedics enter Volodymyr's room and noted CPR was being administered. Oxygen was administered at 03.10. At 03.15 hours the defibrillator was applied and no shockable rhythm was detected.

:paramedics formally declared Voldymyr deceased in his bedroom in Oak Leaf Ward at Shrewsbury Court Independent Hospital at 03:46 on 1 August 2020.

Volodymyr's medical cause of death is as follows:
1a. Fatal ventricular arrhythmia
1b. Left ventricular hypertrophy and ischaemic cardio myopathy
1c. Morbid obesity, diabetes mellitus, hyper cholesterolaemia, hypertension, and obstructive sleep apnoea.

2. Paranoid Schizophrenia/schizo affective disorder.

Paragraph 4 of the Record of Inquest

Natural causes

A. Mental capacity in relation to weight

There was a serious omission on the part of Shrewsbury Court Independent Hospital to assess whether Volodymyr had mental capacity to make decisions in relation to the management of his weight. On the balance of probabilities, Volodymyr lacked mental capacity to make decisions about the management of his weight. A capacity assessment should have been undertaken and a health plan implemented to determine his best interests in relation to his weight and restricting his diet and access to unhealthy food. This would have been practical to implement effectively and would have materially improved Volodymyr's health and clinical progress.
This contributed towards Volodymyr's death.

B. The investigation and management of Volodymyr's cardiac conditions
Volodymyr's ECG undertaken on 15 June 2017 showed as borderline and highlighted three abnormalities which were sinus tachycardia, intra-atrial conduction delay and marked right axis deviation. There was a significant omission on the part of Shrewsbury Court Independent Hospital to send the ECG taken in June 2017 to Volodymyr's GP for further assessment. If Volodymyr's ECG had been reviewed by a competent GP, a referral to a cardiologist would have been made, a further ECG undertaken and an echocardiogram arranged to investigate the ECG results. Volodymyr would have complied with further investigations and treatment incorporating medication. This would have been practical to implement effectively and would have materially improved Volodymyr's health and clinical progress.
This contributed towards Volodymyr's death.

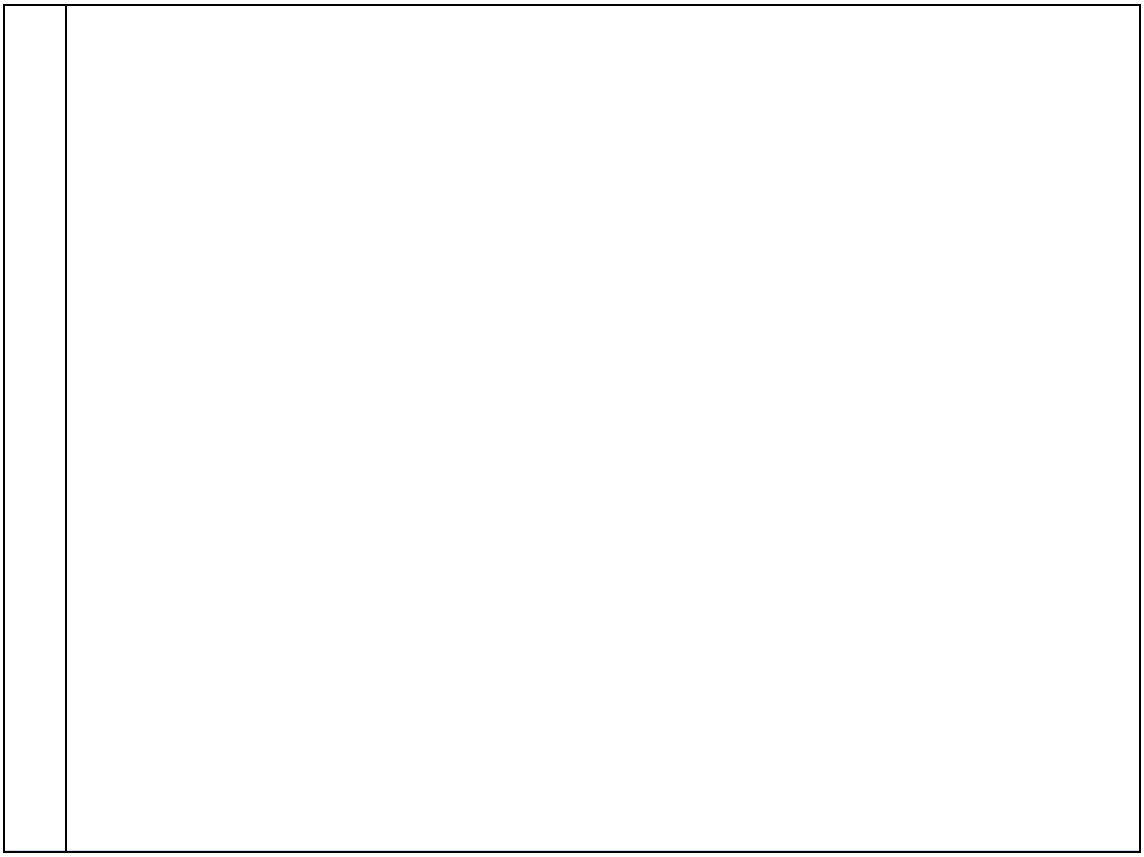
C. The investigation and management of Volodymyr's other physical health conditions
There was a gross omission on the part of Shrewsbury Court Independent Hospital to carry out suitable and timely investigations in relation to Volodymyr's hypertension. Volodymyr would have complied with investigations in relation to his hypertension and would have complied with treatment incorporating medication. This would have been practical

to implement effectively and would have materially improved Volodymyr's health and clinical progress.
There was a serious omission to carry out suitable and timely investigations in relation to Volodymyr's sleep apnoea. It is probable that Volodymyr would not have complied with the investigations, however, it is possible Volodymyr would have complied with treatment to include the use of a CPAP which would have materially improved his health and clinical progress.
It is possible this had a contribution towards Volodymyr's death.

D. The response to the observations recorded on the MEWS chart in July 2020

The purpose of the MEWS chart (Modified Early Warning System) is to monitor the patient's vital signs and to direct how often vital signs need to be completed. In Volodymyr's case, vital signs were required twice a day. The MEWS chart is also a document which serves to track a patient's vital signs over a specified period of time. The MEWS chart also informs practitioner's on how to respond as a result of their findings.
There was a gross failure on the part of Shrewsbury Court Independent Hospital to escalate an unsuitable number of Volodymyr's MEWS results in July 2020. When Volodymyr's vital signs fell into the amber category, Volodymyr should have received competent and immediate care to include, seeking immediate advice of the senior clinician on duty, an increase in frequency and monitoring of Volodymyr's vital signs and the consideration of a GP review.
When Volodymyr's vital signs fell into the red category on five occasions between the 18 July 2020 and 30 July 2020, had the response been escalated, Volodymyr would have received immediate oxygen and been taken to hospital for urgent review.
Had the actions of the staff been adequate, treatment would have materially improved Volodymyr's clinical condition and upon being hospitalised, Volodymyr would have received appropriate care. On the balance of probability, had Volodymyr been in hospital at the time of his cardiac arrest, he would have survived. Therefore, the grossly inadequate response of some of Shrewsbury Court Independent Hospital staff and the absence of actions undertaken, contributed to Volodymyr's death.

The response to the ECG taken in June 2017 – The death was contributed to by neglect.
The response to the observations recorded on the MEWS chart 2020 – The death was contributed to by neglect.



6	**CORONER'S CONCERNS** The Coroner's concerns are as follows: Following Mr Korol's death Shrewsbury Court Independent Hospital did not declare a Serious Incident. As such, whilst there was a 72 hour serious incident review into the events of 31 July and 1 August 2020, there was no investigation into the wider circumstances leading up to his death. Accordingly, none of the matters which form part of the jury's narrative conclusion were identified by Shrewsbury Court Independent Hospital either at the time as part of their own internal investigation or thereafter as part of their preparation for the inquest. The court heard evidence that Shrewsbury Court Independent Hospital has now closed down but that Whitepost Healthcare Group continues to operate one other site, namely Iden Manor Nursing Home in Kent. The **MATTER OF CONCERN** is: The jury found that there were a number of causative failures in relation to the carrying out of mental capacity assessments, the sharing of medical information with other agencies and the appropriate escalation of vital signs which fall outside of normal parameters. All of these issues are equally as important in nursing homes as they are in psychiatric hospitals. Given that these issues were not identified and acted upon by Whitepost Healthcare Group at any point prior to the inquest, the Coroner is concerned that similar practices may be present at Iden Manor Nursing Home in Kent, which would present a risk of future deaths. In the circumstances the Coroner considers that practices should be audited at Iden Manor Nursing Home to ensure that the deficient practices identified by the jury in relation to Mr Korol's care at Shrewsbury Court Independent are not present at Iden Manor Nursing Home.
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 Korol's family 3. Holmhurst Medical Centre 4. Sussex Partnership NHS Foundation Trust 5. Care Quality Commission 6. The Nursing and Midwifery Council
10	**Signed:** **Anna Crawford** **H.M. Assistant Coroner for Surrey** **Dated this 19th day of April 2022**