H G Mark Bricknell
Senior Coroner
for County of Herefordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Hereford County Hospital
1	**CORONER** I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 20 July 2022, I commenced an investigation into the death of Keith Hodson, aged 68 years. The investigation concluded at the end of the Inquest on 5 April 2023. The conclusion of the Inquest was narrative (see 4 below).
4	**CIRCUMSTANCES OF THE DEATH** Mr Hodson had a complex medical history. There were delays prior to an ambulance being called, in connection with the attendance of the ambulance, on admission to hospital and subsequently in connection with appropriate treatment.
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) I am advised that an appropriate Triage System is not always adopted in practice at Accident and Emergency. (2) Without the adoption of a Triage System taking place escalation of care cannot meaningfully take place. (3) I am advised that on occasion appropriate senior oversight does not occur, this is required to identify when a patient has not been appropriately assessed. (4) S.I. reports are not signed off in a timely fashion by a responsible individual.

	(5) Communication with the next of kin appears not to have occurred in a timely fashion. Evidence given at the Inquest identified: The Ambulance crew pre-alerted A and E, but the patient was not triaged using the Manchester Triage System, resulting in missed opportunities to identify the patient's clinical priority. There was subsequently inadequate monitoring. The degree of timely candour with the family is unclear and clarification is required in this regard. It is acknowledged that delays of substance occurred prior to attendance at A and E, but this increases the importance of early assessment and triage procedure.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted] have 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 June 2023 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] 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	18 April 2023 Signature HG Mark Bricknell, HM Senior Coroner: Herefordshire