MR G IRVINE
SENIOR CORONER
EAST LONDON CORONERS
124 Queens Road Walthamstow, E17 8QP

[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **Chief Executive Officer, Barts Health NHS Foundation Trust** 2. **Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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 16 December 2022 this Court commenced an investigation into the death of Claire Twin aged 47. The investigation concluded at the end of the inquest on 13th October 2023. The conclusion of the inquest was a short-form conclusion of a death by natural causes: 1.a. Bronchopneumonia 2. Ventricular Septal Defect And Pulmonary Hypertension (Down's Syndrome)
4	**CIRCUMSTANCES OF THE DEATH**

	Claire Twinn was a 47 year old woman who was born with the chromosomal condition, Down's syndrome. Ms Twinn had a congenital heart defect which resulted in a further condition, Eisenmenger syndrome which adversely affected her respiratory output. Ms Twinn was also assessed to be affected by a severe learning disability. On 15th December Ms Twinn became unwell with symptoms of; a productive cough with yellow sputum, sickness and diarrhoea. Her family took Ms Twinn to the emergency department of Newham General Hospital. An initial rapid assessment identified low oxygen saturations at 61% she was treated with oxygen. Clinical observations were taken and the patient was monitored, blood tests could not be taken as Ms Twinn had a significant phobia of needles. Her learning disability meant that she could not be persuaded to voluntarily provide a blood sample. Similarly, any assessment of potential confusion was made more difficult due to her non-verbal status. It was decided that a blood sample or I/V therapy could only be administered if the patient was sedated. Ms Twinn's complex lung and heart problems meant sedation would carry high risk and was therefore discounted. Ms Twinn had continuous monitoring of oxygen levels, blood pressure and heart rate. A chest x-ray was undertaken that was interpreted by the emergency team as inconclusive of infection despite that, based on history, chest auscultation and a raised temperature, a working diagnosis of bilateral pneumonia was arrived at. A senior doctor took over care of the patient. Oxygen requirement was titrated down from high flow oxygen mask to low flow nasal cannula. Achieving saturations 75% at rest without oxygen, this was patients baseline level from medical notes. Ms Twinn was discharged late in the evening on oral antibiotics, she was found deceased the following morning when her family tried to rouse her from sleep. The Trust now accepts that the more appropriate course would have been to admit Ms Twinn for observation, monitoring of oxygen levels and providing remedial oxygen therapy if a de-saturation occurred. The inquest took expert evidence into account in determining that an admission into hospital would not have, on the balance of probability, resulted in Ms Twinn's death being avoided.--
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 could 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. Ms Twinn's disability played a role in the provision of sub-optimal care, reasonable adjustment was not made for; her inability to communicate clearly and her impaired respiratory function when arriving at clinical decisions. 2. Neither the trust decision to discharge Ms Twinn and not admit for continued monitoring of oxygen levels and remedial oxygen therapy, nor clear safety-netting advice to carers was recorded in the clinical record. 3. Ms Twinn's treatment did not involve any specialised learning disability nursing inpu to facilitate clear communication with Ms Twinn. 4. A radiological report of the chest x-ray taken on 15th December 2023 was not reported until 25th December 2023.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **11th December 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 the family of Ms Twinn. I have also sent it to the Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 16/10/2023 [SIGNED BY CORONER]**