	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Legal Department The Royal Hallamshire Hospital Broomhill Glossop Rd Sheffield S10 2JF
1	**CORONER** I am Tanyka Rawden, Senior Coroner for the Coroner area of South Yorkshire West.
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 7 July 2023 I commenced an investigation into the death of Darnell Errol Hugh Smith, aged 22. The investigation concluded at the end of the inquest on 8 March 2024. The conclusion of the inquest was a narrative conclusion as follows: Darnell Errol Hugh Smith was admitted to the haematology ward at the Royal Hallamshire Hospital on 7 November 2022 with a one week history of a reduced appetite, cough and cold like symptoms and no bowel movements for five days. He was admitted to critical care later that day where he was intubated and ventilated. He remained in critical care until he died on 23 November 2022 There were missed opportunities between the observations taken on admission to hospital and admission to critical care to take observations on an hourly basis for a minimum of six hours in line with his individualised care plan; to provide intravenous fluids; to monitor for pain; to consider Darnell's health passport and his individualised care plan and to escalate any difficulties in obtaining observations or inserting a cannula. This led to a missed opportunity to identify Darnell's condition was deteriorating but it cannot be said that had an earlier review taken place, his death would have been prevented.
4	**CIRCUMSTANCES OF THE DEATH** Darnell Errol Hugh Smith had a past medical history which included cerebral palsy, scoliosis, sickle cell disease and epilepsy. He was wheelchair dependent, non-verbal, and he required 2:1 care. Darnell attended the haematology ward at the Royal Hallamshire Hospital at approximately 6pm on 6 November 2022 with a one week history of a reduced

	appetite, cough and cold like symptoms and no bowel movements for five days. His observations were taken and he was prescribed antibiotics. He returned home. He returned to the Royal Hallamshire Hospital at 1am on 7 November 2022 and was admitted to the the haematology ward. Between his admission at 2.16am and the critical care assessment at approximately twelve hours later, observations were not conducted on an hourly basis for a minimum of six hours in line with his individualised care plan, or every four hours as a minimum as a result or the NEWs 2 score calculated at 2.16am in line with Trust guidelines. Between his admission at 2.16am and the critical care assessment at approximately twelve hours later there were no assessments of Darnell's pain at thirty minute intervals in line with his individualised care plan. Darnell was not provided with fluids in line with his individualised care plan Darnell's health passport was not in the records and was not available to staff until approximately 10.50am on 7 November 2022. Darnell's individualised care plan was in his records but staff were not aware of it. Darnell was admitted to critical care at 4.30pm on 7 November 2022 for sedation and treatment. Darnell responded to treatment initially but by 8am on 8 November 2022 he required additional support to maintain his observations and he was therefore intubated and ventilated. He initially improved from a respiratory perspective but by 16.11.22 he had developed ventilation associated pneumonia By 22 November 2022 he was in type 2 respiratory failure He was extubated and died on 23 November 2022 There were missed opportunities between the observations taken on admission to hospital and admission to critical care to take observations on an hourly basis for a minimum of six hours in line with his individualised care plan; to provide intravenous fluids; to monitor for pain; to consider Darnell's health passport and his individualised care plan and to escalate any difficulties in obtaining observations or inserting a cannula. This led to a missed opportunity to identify Darnell's condition was deteriorating but it cannot be said that had an earlier review taken place, his death would have been prevented.
5	**<u>CORONER'S CONCERNS</u>** 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:

	The Court heard evidence despite a warning 'flag' being present on the computerised records identifying the existence of an individualised care plan for Darnell, the care plan was hard to locate in the records, and was not considered during his admission. Individualised care plans are crucial to a patient's care and it is my view that without knowledge or sight of them by treating clinicians there is a real risk of further deaths.
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 2024. 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: Darnell's family. 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 March 2024 Signature  Tanyka Rawden H.M Senior Coroner for South Yorkshire West.