REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Brian John COLBY (date of death: 16 September 2023)

	THIS REPORT IS BEING SENT TO: 1. [redacted], President and Chief Executive Officer, HCA Healthcare UK, 2 Cavendish Square, London, W1G 0PU.
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North 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.
3	**INVESTIGATION and INQUEST** On 25 September 2023, an investigation was commenced into the death of BRIAN JOHN COLBY, then aged 75 years. The investigation concluded at the end of an inquest, heard by me, on 24 June 2024. The conclusion of the inquest was 'natural causes', the medical cause of death being: 1a acute left sided subdural haematoma (on anticoagulation) II ischaemic heart disease, carcinoma of the liver, chronic kidney disease, interstitial lung disease
4	**CIRCUMSTANCES OF THE DEATH** Brian Colby was an in-patient at The Princess Grace Hospital having had elective surgery. He was in the intensive care unit for treatment of aspiration pneumonia and his condition was improving. On the morning of 16 September 2023, he had a spontaneous, catastrophic intra-cranial event, which was unrelated to his earlier surgery, but likely worsened by his anticoagulation medication. Later that day he was transferred to the National Hospital for Neurology and Neurosurgery where, following assessment and discussion with his family, he was placed on a palliative care pathway. He died later that evening.
5	**CORONER'S CONCERNS** During the course of the investigation and 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.

I have not included within this report, any issues that were identified in the course of my investigation and the inquest where the evidence has already satisfied me that action has been taken to reduce the risks.

The **MATTERS OF CONCERN** are as follows:

(1) At or about 10:00 on 16 September 2023, Mr Colby's vital signs and observations showed a drop in his Glasgow Coma Score from 15/15 (at 09:00) to 11/15, and a clinically significant rise in his blood pressure. I heard evidence that this change in his vital signs and observations was enough to warrant requesting a CT scan to ascertain the cause or causes of the change in clinical presentation. Despite this, I found that this was not escalated as a cause for concern at the time. I heard that the on-call consultant for the intensive care unit (ICU) was not made aware of any deterioration in Mr Colby's presentation until 12:42 that afternoon.

The concern here is that there did not appear to be any, or any clear, protocol(s) in place for the escalation of a deteriorating patient.

(2) At or about 11:00 on 16 September 2023, Mr Colby was routinely reviewed by a medical consultant (i.e. the review did not take place because Mr Colby's condition had been escalated). The medical consultant was immediately concerned by the apparent deterioration in Mr Colby's condition and, as part of a wider plan, the medical consultant requested that a CT head scan should be carried out urgently or as soon as possible. This request was misunderstood and therefore not acted upon by the ICU fellow.

The medical consultant did not record his assessment of, and plan for, Mr Colby until approximately 20:00 that evening. This meant that the entire plan was not available for others to refer back to, if required.

I heard that the record keeping system is currently a hybrid system, comprising some manuscript and some computerised records. I also heard that HCA Healthcare is currently mid-way through commissioning a new patient records system at significant cost.

Notwithstanding the clearly significant ongoing investment in new record keeping software, my concern is not about record keeping per se, it is about communication between clinical staff and expectations in terms of plans of care etc. Both points (1) and (2) involve ineffective communication of clinicians at many levels.

In addition, while I accept that clinical staff may not always be able to complete contemporaneous records and may have to write some records in retrospect, there is no clear procedure or expectation in

	relation to record keeping, particularly in relation to urgent clinical matters, or alternatively, any procedures or expectations are not always followed. (3) On 16 September 2023, the ICU fellow did not arrange a CT scan their self for Mr Colby. I heard that this was because the ICU fellow was working under the mistaken belief that only a consultant could order a CT scan in the private sector. Other evidence confirmed that this was clearly not the case. I heard evidence that, "the authority of resident doctors to commence the scan ordering process in advance of a consultant discussion has now been re-emphasised across the Resident Doctor Training Group." However, when I heard evidence from the ICU fellow, on 22 May 2024, that clinician remained of the view that they did not have the authority to authorise/commence a CT scan. There was a delay in Mr Colby being sent for a scan as a result, albeit there were other delays for different reasons. I am not reassured that the additional training in this regard is having the desired effect and consider that the risk may well remain. (4) When an ICU fellow formed the view that Mr Colby's clinical deterioration did warrant escalation to the on-call ICU consultant, this was done by way of sending the consultant a text message at 12:42 on 16 September 2023. It seems to me that the sending of a text message is not likely to be the most effective way of escalating serious (and presumably urgent) concerns about patients. It carries inherent risks of the message not being delivered and/or not being seen by the recipient in a timely manner. My concern relates to the efficacy of, or possibly the adherence to, any procedures or protocols for the escalation of deteriorating patients. (5) The effective instruction to send Mr Colby for an urgent CT scan was at 13:19 on 16 September 2023, over two hours after an instruction for an urgent or as soon possible CT head scan was given by a medical consultant (albeit it, this instruction was misunderstood) and over three hours after a CT head scan was first clinically indicated. This raises further concern in relation to communication and the escalation of deteriorating patients. The evidence was such that any delays in Mr Colby's escalation and treatment were not causative of his death, but of course, that might not be the case for another patient.
6	**ACTION SHOULD BE TAKEN**

	In my opinion, action should be taken to prevent future deaths and I believe you 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 21 August 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 the following Interested Persons: Mr Colby's wife and children Legal representative acting on behalf [redacted] Legal representative acting on behalf of [redacted] Legal representative acting on behalf of [redacted] I have also sent a copy of my report to the Care Quality Commission, for information. 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. She may send a copy of this report to any person who she 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
	Ian Potter **HM Assistant Coroner, Inner North London** **26 June 2024**