	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Cornwall Partnership NHS Foundation Trust 2. Royal Cornwall Hospitals NHS Trust
1	**CORONER** I am Stephen Covell one of the Assistant Coroners for Cornwall & the Isles of Scilly
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 14 June 2022 I commenced an investigation into the death of Paul Byron Holmes who died on 29 May 2022 then aged 90. The investigation concluded at the end of the inquest on 22 February 2024. The cause of death was lower respiratory tract infection following a period of terminal decline on a background of delirium, frailty of old age, ketoacidosis, poor oral intake/nutrition, type 2 diabetes mellitus, chronic kidney disease and fractured ribs and sternum. I recorded that Paul Byron Holmes was pronounced deceased at 0645 on 29 May 2022 at Arbour Cottage, Mount Hawke, Truro. Paul died as a result of complications including dementia and a chest infection arising from chest injuries sustained in a road traffic collision on 4 April 2022 and subsequent hospitalisation and loss of mobility against a background of frailty. I recorded a conclusion of road traffic collision.
4	**CIRCUMSTANCES OF DEATH**
	i. On 4 April 2022 Paul was a passenger in a vehicle involved in a road traffic collision as a result of which he sustained chest injuries comprising fractured ribs and a fractured sternum ii. Paul was admitted to the emergency department of the Royal Cornwall Hospital Truro the same day for treatment of his injuries. Although Paul was initially lucid, over the subsequent few days he developed delirium which was probably due to a combination of the trauma, his age and frailty, the painkilling medication and disorientation being in a busy acute hospital. iii. On the evening of the 16 April 2022 Paul was transferred from the Royal Cornwall Hospital to Liskeard Community Hospital. Paul's medical condition had stabilised and it was felt that a community hospital was the best location for rehabilitation and for his delirium to settle. The clinician with care of Paul felt that his prognosis was guarded although that was not communicated to Paul's family. iv. Unfortunately Paul's condition deteriorated on 17 April 2022. The nursing staff had

difficulty encouraging Paul to eat and hydrate, his heartrate and rate of breathing had increased. Those treating him felt that Paul was suffering from an infection. A decision was taken to transfer Paul back to the Royal Cornwall Hospital which took place in the early hours of 18 April 2022.

v. At the Royal Cornwall Hospital Paul was given Intravenous antibiotics and fluids. It was felt that Paul did not have an infection and that the principal issue was dehydration. By late morning on 18 April 2022 clinical staff considered that his condition had stabilised and he could be transferred back to Liskeard albeit that his dehydration had not resolved and intravenous fluids needed to be continued.

vi. Because of Paul's ongoing dehydration and overall frailty there needed to be a robust and detailed handover between treating doctors from the two hospitals as to the ongoing treatment plan and what to do in the event of Paul deteriorating. This did not take place. There was a nurse to nurse handover without sufficient details being exchanged or recorded, particularly with regard to the unresolved dehydration. There was also an error in the date of the prescription for the intravenous fluids which resulted in a delay to Paul receiving fluids.

vii. Paul's condition deteriorated again resulting in him being transferred back to the Royal Cornwall Hospital at 18.45 the same day where he received appropriate treatment for dehydration and a possible infection.

viii. Unfortunately whilst Paul's condition stabilised his delirium persisted and it was felt that he should return home for palliative care. Paul returned home on 16 May where he died on 29 May 2022.

ix. The planning and handover for Paul's transfer between the Royal Cornwall Hospital and Liskeard Community Hospital at around midday on 18 April 2022 was inadequate and caused significant discomfort and distress to Paul and a delay to the treatment of the dehydration. It did not however cause or contribute to Paul's death over a month later.

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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.

On Paul's transfer from The Royal Cornwall Hospital to Liskeard Community Hospital on 18 April 2022

(1) There was no clear, detailed and direct handover between doctors of the two hospitals

(2) A treatment plan including the need to continue to treat Paul for dehydration and what to do in the event of deterioration was not agreed and recorded clearly between clinical staff of both hospitals

(3) Any handover which did take place was not properly recorded in Paul's medical notes

(4) An error in the writing out of a prescription for intravenous fluids at the Royal Cornwall meant that the administration of hydrating fluids at Liskeard Community Hospital was delayed.

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 by 22 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 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	27 June 2024 Signature  Stephen Covell Assistant Coroner for