MR G IRVINE
SENIOR CORONER
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Officer, Barts Health NHS Foundation Trust** **Sent via email: [redacted]** **2. [redacted], Secretary of State for Dept. Health & Social Care** **Sent via email: [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 3rd November 2023 this court commenced an investigation into the death of Terence Harry Clark, aged 76. The investigation concluded at the end of the inquest on 27th August 2024 when the court returned a narrative conclusion. *"Terence Harry Clark died in hospital on 1st November 2023. Mr Clark had numerous co-morbidities including an impaired swallow. On 26th October 2023 he was admitted to hospital by ambulance with aspiration pneumonia. On 1st November 2023 he was fitted with a naso-gastric tube which required radiological confirmation of its siting. Mr Clark*

	sustained a cardiac arrest whilst waiting unescorted in the X-ray waiting area." Mr Clarks medical cause of death was determined as; 1a Aspiration Pneumonia 1b Right Frontal Lobe Ischaemic Stroke, Dementia II Chronic Obstructive Pulmonary Disease, Diabetes Mellitus
4	**CIRCUMSTANCES OF THE DEATH** Terence Harry Clark was 76-year-old man with considerable co-morbidity, including a compromised swallow, dysphagia. Mr Clark was admitted to hospital by ambulance on the evening of 26th October 2023 with difficulty in breathing. Mr Clark was diagnosed with bilateral aspiration pneumonia. The deceased was admitted and treated with anti-biotics. Mr Clark was assessed by the speech and language team who advised that to protect his airway from further aspiration he should be made subject to a nil by mouth order pending the trial of feeding using a naso-gastric ("NG") tube. On 1st November 2023 Mr Clark underwent NG tube insertion which required an x-ray to ensure that the tip of the tube was correctly sited in his stomach, and not in an airway. It is reported that prior to an x-ray no feed was introduced via the apparatus. Against Trust policy, Mr Clark was sent to the imaging suite unescorted by nursing or medical staff. Mr Clark's x-ray was never completed, passing members of trust staff found Mr Clark, unresponsive in the imaging suite waiting area and alerted their radiology colleagues. As Mr Clark was unescorted, little was known about the patient. CPR was commenced and subsequently discontinued when it was learned that the patient had a do not attempt cardio-pulmonary resuscitation order in place. Mr Clark was declared deceased.
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. – A. Despite Mr Clark having been subject to a nil-by-mouth order for 24 hrs prior to collapse, cream-coloured liquid food was found in Mr Clark's airway at autopsy. The NG tube, inserted on the day of death had been removed and misplaced prior to autopsy. No evidence exists to indicate, when the apparatus was removed, by whom, on whose instruction or why. The removal and loss of this apparatus impeded the proper investigation of this death. B. The Trust conducted a patient safety investigation into the circumstances leading to Mr Clark's death, the investigation did not identify the removal of the NG tube as a significant factor worthy of scrutiny. Both of these issues raise a concern that the Trust can not adequately secure and review evidence relevant to governance and coronial investigations, necessary to mitigate risks of future fatalities.
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 **25th October 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 the family of Mr Clark, the Care Quality Commission and to the local 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] 30/08//2024 [SIGNED BY CORONER]**