Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
Telephone: 0300 061 6161
www.cqc.org.uk

HM Coroner
The Coroners Courts & Office
The Guildhall
Alfred Gelder Street
Kingston upon Hull

3 February 2025

Dear HM Coroner (Mr Edward Steele, Assistant Coroner)

Regulation 28 Report following the inquest into the death of Mr David Christopher Peter Lodge.

We are sorry to hear about the death of Mr Lodge and we offer our sincere condolences to his family.

We provide the formal response of the Care Quality Commission (CQC) to the Regulation 28 Preventing Future Deaths report made by HM Coroner (Mr Edward Steele, Assistant Coroner) following the inquest into the death of Mr Lodge. ('the Regulation 28 Report').

In the Regulation 28 Preventing Future Deaths report HM Coroner raised the following concerns:

1. Pain is not accurately assessed in people who are unable to communicate with words. The court heard evidence that Mr Lodge at no point was provided pain relief, despite requests from the attending family member who was speaking on his behalf.

2. Basic examinations, including chest examinations, are not being carried out for learning disabled adults at risk of pneumonia in the emergency department. The treating physicians in evidence agreed that there should have been a high index of suspicion of pneumonia in Mr Lodge's case and that it is one of the leading causes of death for people with learning disabilities. The court heard evidence that Mr Lodge did not have a chest examination carried out on him due to him not presenting any signs of respiratory distress.

3. NEWS2 scores above seven are not appropriately escalated for specialist advice. Clinical recommendations for 30-minute observations were not being followed.

4. Opportunities for learning from serious incidents are being lost. No internal investigation or other form of serious incident investigation was undertaken. This regulation 28 report sets out the following matters of concern for CQC to address.

The trust's last comprehensive inspection was in November 2022 and the report was published in March 2023. CQC rated the trust as "Requires Improvement". A copy of the report can be found on our website - Trust - RWA Hull University Teaching Hospitals NHS Trust (23/03/2023) INS2-13905362001 (cqc.org.uk)

During this inspection serious concerns were identified in Urgent and Emergency Care (UEC) that led to the CQC subsequently issuing an urgent enforcement action – Section 31 of the Health and Social Care Act 2008.

The Commission had reasonable cause to believe that any person will or may be exposed to the risk of harm arriving from the following:

- The identification and management of deteriorating patients.
- The inability to demonstrate that fundamental standards of care are being met.
- Management of patients waiting within the department.

Immediate assurances were requested by the CQC that the trust had mitigated the risks identified by 4th of November 2022. Assurances were provided and accepted by the CQC.

The trust was required to submit an action plan by the 8th of November 2022 to indicate actions taken and any further steps to be taken to mitigate immediate risks to patient safety as identified above. This action plan was submitted, and accepted, by CQC within the required timeframe.

The trust also provided details of the longer-term actions required to ensure the improvements would become sustained and embedded. The CQC continues to closely monitor progress against all action plans to ensure sustained improvement through regular engagement with the trust.

In addition to inspection activity the CQC attends a monthly Quality Improvement Group (QIG) chaired by NHS England, where the trust presents monthly updates against the CQC action plans and key priority areas. The purpose of the QIG is to support planning, coordination and facilitate the sustained delivery of actions to mitigate and address the quality risks within the trust.

CQC first became aware of the death of Mr Lodge on receipt of the Regulation 28 Report on 23 December 2024.

CQC asked Hull University Teaching Hospitals NHS Trust to provide evidence of any action they had taken to date following the tragic death of Mr Lodge and we are waiting for their response.

CQC will continue to closely monitor information we receive about the service. Where CQC identifies that regulations are not being met, we will use our enforcement powers to require improvements to be made.

CQC will also check the provider's compliance with the regulations on our next inspection of the service using our new single assessment framework methodology in accordance with the CQC regulatory remit. CQC will highlight any repeated or new breaches of regulation and ask them to make necessary improvements.

CQC's next inspection of the service is not yet confirmed, however we have adopted a more risk-based approach to inspections should CQC receive negative intelligence or have further concerns about the service we would carry out responsive inspections.

CQC hope that this response addresses your concerns.

Yours sincerely

[redacted]
Deputy Director of Operations
North Network