ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Hull University Teaching Hospitals NHS Trust.** **2. NHS England.** **3. Care Quality Commission.**
1	**CORONER** I am Mr Edward Steele, assistant coroner, for the coroner area of East Riding of Yorkshire and City of Kingston Upon Hull.
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 20 January 2022, I commenced an investigation into the death of David Christopher Peter Lodge ("Mr Lodge"), aged 40 years. The investigation concluded at the end of the inquest on 20 December 2024. The conclusion of the inquest was Natural Causes contributed to by Neglect. Box 3 of the Record of Inquest read: David Christopher Peter Lodge, who had a learning disability, was found on 12 January 2022 unwell next to his deceased carer/father, after having had up to a four day long lie. He was treated at Hull Royal Infirmary, where he was treated for dehydration, and later died on 13 January 2022 from bilateral pneumonia. No chest examination was performed and there was a missed opportunity to transfer to the intensive care unit. His medical cause of death was recorded as: **1a** Bilateral Pneumonia **1b** Metabolic Acidosis and Hypovolaemia **1c** Dehydration **II** Autism, Learning Disability, Dysarthria and Immobility.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lodge had a learning disability and was cared for by his father, who sadly passed away at their home address. Unable to seek assistance, Mr Lodge endured a long lie by his father's side for up to four days, before being found by another family member. He was taken to Hull Royal Infirmary at 12 January 2022 and sadly died mid-morning at 13 January 2022. Mr Lodge was being treated for dehydration and died of bilateral pneumonia.

	Whilst at the hospital, Mr Lodge was agitated and, therefore, given sedative medication on two occasions to calm him down in order to permit full observations. Meanwhile, Mr Lodge's NEWS2 scores were consistently high at 8 or 9 for a number of hours and during that time no chest examination was undertaken. Intensive care specialists were consulted by the emergency department treating physicians, and no referral eventuated. Mr Lodge was, instead, transferred to the acute admissions unit, was not medically assessed again and he later suffered a cardiac arrest and died hours later.
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 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. – (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. An independent expert, a Consultant in Emergency Medicine, gave evidence that there was no evidence of reasonable adjustments in respect of assessing Mr Lodge's pain to account for his baseline condition. (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. The independent expert gave evidence that a thorough examination should have been undertaken and that there was the opportunity to do so after the sedation medication was given. (3) NEWS2 scores above seven are not appropriately escalated for specialist advice. Clinical recommendations for 30 minute observations were not being followed. An independent expert, a Consultant in Intensive Care, gave evidence to the court that Mr Lodge should have been admitted to the Intensive Care Unit at Hull Royal Infirmary at which Mr Lodge would have undergone closer examinations on a lower patient to nurse ratio. (4) Opportunities for learning from serious incidents are being lost. No internal investigation or other form of serious incident investigation was undertaken. The court heard evidence from independent experts who opined that it would be expected, following a death in these circumstances, for there to have been an internal review to consider improvements to include input from a specialist with a learning disability team.
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 17 February 2025. 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 David Christopher Peter Lodge. 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	**[DATE]** **[SIGNED BY CORONER]** **23 December 2024** **HM Assistant Coroner Edward Steele**