COUNTY OF DEVON, PLYMOUTH AND TORBAY CORONER AREA

REPORT ON ACTION TO PREVENT OTHER DEATHS
Linda Brooks

HM AREA CORONER
Deborah Archer

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive – Torbay and South Devon NHS Trust**
1	**CORONER** I am Deborah Archer, Area Coroner for the County of Devon, Plymouth and Torbay.
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 24th May 2022 I commenced an investigation into the death of of Linda Brooks aged 78. The investigation concluded at the end of a 2-day inquest on 30th January 2026 the conclusion of the inquest was a narrative one namely: **Narrative** The deceased died at Torbay Hospital on 17.5.22 as a result of bronchopneumonia, rib fractures and respiratory distress in circumstances where the inadvertent switching off of oxygen for an unknown period of time in the day before her death possibly caused or contributed to her death .
4	**CIRCUMSTANCES OF THE DEATH** Linda Brooks was a 78-year-old lady who lived in a Care home and had the following comorbidities: health anxiety, COPD, asthma and ischaemic heart disease. She had a fall at her care home which caused an admission to Torbay Hospital on 16th April 2022. Initially no fractures were seen, and she was treated with oxygen therapy at lower levels than would be seen in a person without respiratory compromise because too much oxygen can cause in COPD patients a reduction in respiratory drive and further Co2 retention. She was transferred from the Emergency department to Forrest Ward where rib and pubic Rami fractures were diagnosed and it was discovered that she had small blood clots . On 22nd April 2022 it was felt that given her high risk of falls and co-

morbidities, the risks of potential bleeding if on anticoagulation, meant that the blood clots should not be treated, and therefore she went back to prophylactic clot prevention dose Dalteparin.

On 29th April 2022 , multiple gastric erosions and three duodenal ulcers were diagnosed and treated accordingly. An increase in oxygen requirement on 4th May 2022 with new change on chest x-ray, lead to an increase in her diuretic therapy and a switch to a stronger form of intravenous antibiotic for a hospital-associated pneumonia. Her oxygen requirements fluctuated during the admission. Multiple blood gases showed that she remained very sensitive to over-oxygenation, which would cause her to hypo-ventilate further, therefore it was recommended that she remain at target oxygen saturations of 88- 92%, She was gradually weaned to oxygen via nasal cannula. There was a steady improvement in inflammatory markers, and she was discharged to Templar Ward at Newton Abbot Community Hospital on 10th May. once she had stabilised on oxygen requiring the least possible feed namely 0.5 l .
By the 13th of May 2022 she had weaned to a minimal level of oxygen, she was found to have a new irregular heart rhythm, known as atrial fibrillation.

Mrs Brooks was stable, eating, drinking and mobilising well and appeared to be improving sufficiently to begin the process of returning home when on 16th May 2022 there was a note in the nursing records that Mrs Brook's Oxygen had been turned off . This appears to have happened sometime between 2007 and 2130 when it was noted that oxygen was not turned on at the wall . Asked about whether someone could have knocked the dial inadvertently the consensus was that it was not easily done- and certainly not easily done by a frail patient such as Mrs Brooks. The Hospital Matron was able to say that at 2130 when this was discovered Mrs Brook's Oxygen saturation levels had dropped to a very low level as confirmed by the Consultant, well below even the lowest levels recommend for COPD patients at 88 percent, namely 74 %. The Trust accepted that a DATIX should have been made at the time, and failing that should have been made retrospectively.
SWAST attended to convey Mrs Brooks to the acute hospital and made a DATIX referral about this incident as they were concerned that the incident had happened and about the attitude of staff at the hospital but due to human error this DATIX was never shared with the Hospital Trust although there was a process for that to happen.
Mrs Brooks was seen at the acute hospital where she sadly passed away on 17th May 2022 and the Consultant who gave evidence at inquest accepted that she did not make a DATIX or any other type of report and neither did she escalate this concern as the ambulance service had already done so .
The Inquest was not able to unpick how this error had happened as it was never investigated contemporaneously or at all.

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. –

	1. There appeared to be a lack of training and understanding by staff at the Trust that it is everybody's responsibility to report and escalate a serious clinical incident such as this 2. There appears to be no effective process in place for reviewing clinical notes to pick up a clinical issue such as this in circumstances where no complaint has been made by a family member, and no member of staff has recognised or reported it . 3. There appears to be a lack of understanding as to when a Serious Incident Report should be made or actioned retrospectively 4. There appeared to be no process for recording the fact that another organisation such as SWAST had made a Datix referral which would then have mitigated the fact that the SWAST Team failed to pass on their own DATIX to Torbay and South Devon NHS Trust.
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 4pm on 7th April 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], SWAST and I have also sent it to NHS England and the Devon Integrated Care Board who may find it useful or of interest. 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	**6th February 2026** [redacted] **Deborah Archer – Area Coroner for County of Devon, Plymouth & Toraby**