The medical registrar reviewed the patient again at 15:36 and recorded within the patient's medical records that she had been declined ITU admission due to cardiac comorbidities and Down's Syndrome. The investigating team have been unable to find any documented evidence of an ITU review taking place and can conclude that the patient was not reviewed face-to-face by ITU staff. A contemporaneous record of conversations held between the admitting ITU consultants on 27 March 2020 and any reasons for declining ITU admission does not show that the patient was discussed for consensus opinion for ITU suitability, as was the recognised process at the time. This led the review team to conclude that either the patient was not discussed at a consultant level or that the discussion was not recorded.

The reviewing team considered the degree to which the patient's cardiac comorbidities would be a reason for not admitting to ITU and agreed that the presence of moderate to severe mitral and aortic regurgitation and a cardiac pacemaker would not be exclusion factors for ITU on their own but that they could certainly adversely affect patient outcomes from Covid-19. The reference to Down's Syndrome as a reason for not admitting to ITU was also reviewed and again agreed that this is not a reason for declining ITU admission however there was a recognition that in a cohort study of 8.26 million adults, as part of the wider Covid-19 risk prediction project commissioned by the U.K. government, Down Syndrome presented an estimated 10-fold increased risk for covid-19 related death. As part of the investigation process all ITU consultants interviewed confirmed that neither the presence of a cardiac pacemaker or Down's Syndrome are considered exclusion criteria for ITU review or possible admission.

It is recognised that intensive care units were having to clinically prioritise patients for admission to ITU at this time. Occupancy data for the I&S ITU for 27 March was 27 level 3 patients (an increase from 21 patients on 26 March) [Level 3 patients are those requiring two or more organ support or needing mechanical ventilation with 1-to-1 nursing and access to a doctor 24 hours per day]. The I&S ITU baseline capacity was 23 beds (normally staffed for 9 level 3 patients and 14 level 2 patients) and on 27 March 2020 had already exceeded this. In response to the pandemic, ITU had expanded into a neighbouring ward however, by 5 April 2020 it had reached its maximum surge capacity of 40 patients.

The patient's observations at 15:36 were within the target range of 94-98% on oxygen and may therefore not have been considered to be the most critically urgent patient for ITU admission at this time. The reviewing team were made aware that on 27 March 2020 ITU was admitting patients that were clinically desaturating despite receiving high flow oxygen.

In the afternoon of 27 March, the patient was transferred to I&S ward and was at that time for full escalation of treatment despite not being considered suitable for ITU.

At approximately 20.16 the medical registrar informed the patient's brother that she had made some improvement, but that this was dependant on the patient keeping her oxygen mask on. The registrar handed over at the end of their shift that the patient's escalation status should be kept under review and to discuss again with ITU if oxygen saturation levels dropped below 90% on 60% oxygen and to encourage the patient to keep the oxygen mask on.

On Saturday 28 March 2020 at 04:10, nursing notes document that the patient was alert and that her vital signs were stable.

At 06:45, a medical specialist registrar (SpR) was asked to review the patient as her blood pressure had dropped and her oxygen levels had started to desaturate. Evidence pertaining to this time suggests that the patient was able to maintain higher oxygen saturations whilst her oxygen mask was worn but that desaturation occurred whenever this was removed. The medical SpR arranged with the nurse in charge for the patient to be moved into an open bay and to have 1-to-1 support to aid and encourage the patient to keep her face mask on. The SpR called the patient's brother, stating that the medical team would re-discuss the patient's treatment with the ITU team.

previous medical history, and no evidence of a face-to-face review by a member of the Critical Care team.

It is not possible to clearly decide one way or another if the patient should have been admitted to ITU. However, the lack of a detailed critical care assessment and insufficient justification for refusal for ITU admission will have influenced future clinical decision making. Nonetheless, the chest X-ray findings, clinical observations, and available treatment options for covid-19, presented a poor prognosis for survivability.

2. **To determine if sufficient reasonable adjustments were made in light of the patient's learning disabilities.**

Discrepancies in the documentation of the patient's ability to communicate may have affected staff decision-making/behaviour. The patient's deemed lack of capacity to make decisions about treatment escalation is not clearly justified in the notes. The patient may well have lacked capacity due to her background of learning difficulties and acute illness and delirium, but this is not clearly documented. In this event, a clear history is needed from the family regarding the patient's wishes and pre-morbid state. Whilst conversations did take place with the family, mostly the patient's brother, clarity regarding the patient's capacity was not fully documented.

The patient was not referred to the acute liaison nurse for learning disabilities and resultantly there is no evidence to suggest the Trust's Learning Disability Team were involved in the patient's care despite the service being available throughout the pandemic. This may in part have been due to the relatively short time the patient was in I&S (~28 hours) and that this service is not available at weekends.

It is understood that the family were keen to be present with the patient in hospital, but that this was not permitted. The Trust's first compassionate visiting policy was published on 20 October 2020. Prior to this, starting 8 April 2020, all Trusts deferred to NHS England guidance on visiting. According to the NHS England directives, patients with a learning disability should be entitled to some form of visiting. However, before this date, there was limited guidance on visiting patients with Covid and it would have been considered usual to deny the family entrance to clinical areas during this phase of the pandemic. At this time, the Trust did permit one visitor to be present in the final hours of the patient's life.

It is difficult to determine if sufficient reasonable adjustments were made in light of the patient's learning disabilities. The reviewing team recognise that no family member was allowed to be present until the latter stages of 28 March, however there is documented evidence that the SpR and nurse in charge arranged for 1-to-1 support for the patient and that when she became restless a healthcare assistant would sit with her and help her to relax and keep her mask on. Given the context of the pandemic, whilst any additional 'reasonable adjustments' may not have been possible, deemed safe at the time, or altered the outcome, it is accepted that the presence of family may have provided a better experience for the patient and for the family during her hospital admission.

3. **To determine which relevant policies and national guidance was in place at the time and whether these were followed.**

On 16 March 2020 NHS England produced a number of speciality guides for patient management during the coronavirus pandemic (see reference list). These documents state that 'Routine practice should include discussion and documentation of DNAR status and appropriate limits of effective therapy, on admission to the hospital'. Resuscitation status (i.e. that the patient was for resuscitation) was indeed documented on admission by the medical SpR, but the decision was reversed the next day at the consultant ward round as the outlook was now very poor and any further lifesaving interventions were unlikely to be successful – this rationale was not clearly stated within the patient's records.