REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Chief Executive - University College London Hospitals NHS Foundation Trust**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North 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.
3	**INVESTIGATION and INQUEST** The investigation into the death of Peter John BROOKES, aged 80, was commenced on 3 September 2013 and concluded at the end of the inquest on 30 April 2014. The conclusion of the inquest was narrative [redacted] .
4	**CIRCUMSTANCES OF THE DEATH** Mr Brookes had a background medical history which included Parkinson's disease (PD) and ischaemic heart disease. He was admitted to University College Hospital (UCH) in early August 2013 for removal of a cancerous skin lesion. He was catheterised post-operatively. This resulted in some bleeding, which was thought to be resolving and the catheter was removed. The bleeding recurred, which resulted in a short readmission to UCH and warranted reinsertion of a catheter. Mr Brookes was admitted for a third time on 17 August after the catheter became blocked. During this admission there were issues regarding the sourcing and administration of Mr Brookes' PD medication, meaning that he did not receive his medication as prescribed. On 18 August Mr Brookes had a period of 'agitation' and rapid breathing, which the nursing staff felt warranted review by the ward doctors, although his symptoms did resolve after administration of pain relief. This review did not occur despite repeated requests from the nursing staff. I heard evidence that weekend ward rounds routinely take most of the day to complete, which might mean that the on-call team were so busy that non-emergency reviews would not occur. In the morning of 19 August Mr Brookes suffered a respiratory arrest, which resulted in his admission to the Intensive Care Unit (ICU). Subsequent investigations demonstrated that Mr Brookes had suffered a heart attack. Whilst on the ICU it was discovered that one of the PD medication boxes (Amantadine) actually contained another medication, as a consequence of a dispensing error in the hospital pharmacy. There was no evidence that

	Mr Brookes had been administered the wrong medication. Mr Brookes developed bronchopneumonia and continued to deteriorate, despite ongoing medical treatment. He died on 27 August 2013.
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) I heard evidence that the administration of PD medication in hospital routinely does not follow patients' usual regimens and that this, in itself, could cause physiological stress and contribute to early death. It was not possible conclude that, on the balance of probabilities, this was the case in Mr Brookes death but it was clear that this was a continuing risk, which could result in future deaths. (2) The risks posed by the unavailability of doctors for non-emergency reviews, during weekend shifts, raises concern that future deaths could occur as a consequence. (3) The cause of the dispensing error, that resulted in the wrong medication being put in a box labelled as 'Amantadine', was not elucidated during the inquest and raises concern that future similar errors could recur, with potential for future deaths resulting.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that you, as the Chief Executive of the Trust, 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 2 July 2014. 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 (a) The Brookes family, (b) The Care Quality Commission 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	**07 May 2014** **Assistant Coroner R Brittain**