REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Partners, Tredegar Practice, 35 St Stephen's Road, London.**
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** Stephen Atherton died on 16 May 2013, aged 27. On 21 May 2013 an investigation was commenced into his death. The investigation concluded at the end of the inquest on 10 October 2014. The conclusion of the inquest was narrative and the medical cause of death was severe head injuries following a fall from height. This resulted from the consequences of steroid-induced mood alteration. This steroid medication was being used in the management of metastatic neuroendocrine carcinoma (see attached).
4	**CIRCUMSTANCES OF THE DEATH** Mr Atherton developed shoulder pain towards the end of 2012. At visits to A&E and his GP practice this was attributed to his work as a brick layer. He re-presented to his GP in January 2013. An x-ray of his shoulder demonstrated an abnormality, which the reporting radiologist recommended should be further evaluated by a bone scan. This investigation was requested by his GP and a referral was made to the orthopaedic department at the Royal London Hospital (RLH). The results of this scan demonstrated findings in his chest, which warranted further investigations that could not be requested by the GP (a CT and MRI). A fax was sent by the GP to the orthopaedic department, requesting that the date of Mr Atherton's 'choose and book' outpatient appointment be brought forward from late March, given the results of the bone scan. This fax was either not received by the orthopaedic department, or received but not scanned into Mr Atherton's notes. The GP was not able to demonstrate that the fax was successfully delivered. In early March 2013 Mr Atherton developed problems with his speech. He was referred to the on-call medical team at the RLH and was subsequently diagnosed with a metastatic neuroendocrine carcinoma. He underwent chemotherapy treatment. He was also found to have a metastatic tumour deposit in his brain, which resulted in referral to the neurosurgical department at RLH. Mr Atherton underwent removal of the metastatic brain tumour in early May 2013. As part of the post-operative management plan he was put onto a reducing dose of steroid medication. His treating neurosurgeon was aware of the potential contribution this was having on Mr Atherton's low mood but it was felt that he was safe to be discharged on 13

	May 2013. Two days later he began displaying unusual behaviour and expressing suicidal ideation to his partner. He was brought to A&E at RLH where he underwent a CT scan of his head. This demonstrated expected post-operative findings only. There were delays in him being seen by the neurosurgical registrar, after which he was admitted to the ward, having been in A&E for almost seven hours. The registrar had discussed Mr Atherton's case with his neurosurgical consultant and the plan was for an urgent psychiatric assessment, given the history of suicidal ideation. Following a handover process to a neurosurgical senior house officer (SHO) and from that SHO to the night SHO, the urgency of the psychiatry referral and the history of suicidal ideation was not communicated. As such no referral was made on 15 May 2013. The following morning Mr Atherton had a further episode of unusual behaviour. He asked to go to the ward television room and was accompanied by a healthcare assistant (HCA). However, he subsequently managed to leave the ward, contrary to the efforts of the HCA. The hospital security staff and police were informed following this incident. However, Mr Atherton was found shortly afterwards, having fallen to his death at a nearby residential housing block.
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) It was clear from the evidence at the inquest that Mr Atherton's GP was concerned that he should be seen for orthopaedic review more quickly than had been planned. However, was concerned that, given the importance of this further correspondence, there was no system in place at the GP practice to ensure successful receipt of the fax.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the addressees 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 12 December 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) Mr Atherton's family (b) Barts Health NHS Trust. I have also provided a copy of this report to Tower Hamlets CCG. 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	**17 October 2014** **Assistant Coroner R Brittain**

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive, Barts Health NHS Trust, Trust headquarters, Executive Offices, Ground Floor, Pathology and Pharmacy Building, The Royal London Hospital, 80 Newark Street, London, E1 2ES**
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** Stephen Atherton died on 16 May 2013, aged 27. On 21 May 2013 an investigation was commenced into his death. The investigation concluded at the end of the inquest on 10 October 2014. The conclusion of the inquest was narrative and the medical cause of death was severe head injuries following a fall from height. This resulted from the consequences of steroid-induced mood alteration. This steroid medication was being used in the management of metastatic neuroendocrine carcinoma (see attached).
4	**CIRCUMSTANCES OF THE DEATH** Mr Atherton developed shoulder pain towards the end of 2012. At visits to A&E and his GP practice this was attributed to his work as a brick layer. He re-presented to his GP in January 2013. An x-ray of his shoulder demonstrated an abnormality, which the reporting radiologist recommended should be further evaluated by a bone scan. This investigation was requested by his GP and a referral was made to the orthopaedic department at the Royal London Hospital (RLH). The results of this scan demonstrated findings in his chest, which warranted further investigations that could not be requested by the GP (a CT and MRI). A fax was sent by the GP to the orthopaedic department, requesting that the date of Mr Atherton's 'choose and book' outpatient appointment be brought forward from late March, given the results of the bone scan. This fax was either not received by the orthopaedic department, or received but not scanned into Mr Atherton's notes. The GP was not able to demonstrate that the fax was successfully delivered. In early March 2013 Mr Atherton developed problems with his speech. He was referred to the on-call medical team at the RLH and was subsequently diagnosed with a metastatic neuroendocrine carcinoma. He underwent chemotherapy treatment. He was also found to have a metastatic tumour deposit in his brain, which resulted in referral to the neurosurgical department at RLH. Mr Atherton underwent removal of the metastatic brain tumour in early May 2013. As part of the post-operative management plan he was put onto a reducing dose of steroid

	medication. His treating neurosurgeon was aware of the potential contribution this was having on Mr Atherton's low mood but it was felt that he was safe to be discharged on 13 May 2013. Two days later he began displaying unusual behaviour and expressing suicidal ideation to his partner. He was brought to A&E at RLH where he underwent a CT scan of his head. This demonstrated expected post-operative findings only. There were delays in him being seen by the neurosurgical registrar, after which he was admitted to the ward, having been in A&E for almost seven hours. The registrar had discussed Mr Atherton's case with his neurosurgical consultant and the plan was for an urgent psychiatric assessment, given the history of suicidal ideation. Following a handover process to a neurosurgical senior house officer (SHO) and from that SHO to the night SHO, the urgency of the psychiatry referral and the history of suicidal ideation was not communicated. As such no referral was made on 15 May 2013. The following morning Mr Atherton had a further episode of unusual behaviour. He asked to go to the ward television room and was accompanied by a healthcare assistant (HCA). However, he subsequently managed to leave the ward, contrary to the efforts of the HCA. The hospital security staff and police were informed following this incident. However, Mr Atherton was found shortly afterwards, having fallen to his death at a nearby residential housing block.
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 routine 'choose and book' orthopaedic referrals are not clinically triaged by the specialist to whom the referrals are made. As such, the concern was raised (which I share) that there is no potential for the triaging of apparently 'routine' appointments which, with specialist input might be expedited. It was clear from the evidence heard that other departments routinely triage referrals and no evidence was provided as to why this is not undertaken by the orthopaedic department. (2) Mr Atherton required multiple investigations of increasing complexity, at the recommendation of the reporting radiologists. I heard compelling evidence from Mr Atherton's GP that this process results in delays. This is because the investigations could be undertaken more quickly if the radiologists themselves instigated the necessary additional investigations. This is particularly the case where the suggested investigations cannot actually be requested by GPs. The Trust gave evidence that this process is necessary because of the commissioning arrangements in place, which determine how payment is made for such tests. I am concerned that this process could increase the risk of future deaths occurring in similar circumstances to Mr Atherton's case. (3) The neurosurgical ward from which Mr Atherton self-discharged was not locked. This was despite the risk he posed to himself and the fact that the staff were clear he should not be free to leave, without medical assessment of his capacity to self-discharge. I heard evidence that the current legislative framework and case law means that locking of wards is not acceptable. Whilst it is clear that locking ward doors by default is not appropriate, I did not hear compelling evidence as to why mechanisms could not be put in place to facilitate temporary locking. I am concerned that the legal position is being interpreted so that no appropriate safeguards exist, which would have prevented Mr Atherton from absconding. This raises concerns that future deaths could result in such circumstances, if this issue is not addressed.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the addressee 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 12 December 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) Mr Atherton's family (b) Tredegar GP practice. 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	**17 October 2014** **Assistant Coroner R Brittain**

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Officer, NHS Tower Hamlets Clinical Commissioning Group, 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London E1 4DG** 2. **National Director for Commissioning Strategy, NHS England, PO Box 16738, Redditch. B97 9PT** 3. **A separate report, including the issue of concern, is being sent to: Chief Executive, Barts Health NHS Trust, Trust headquarters, Executive Offices, Ground Floor, Pathology and Pharmacy Building, The Royal London Hospital, 80 Newark Street, London, E1 2ES**
1	**CORONER** I am R Brittain, assistant coroner, for Inner North London
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