	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **Re: Master Thomas Warren** **THIS REPORT IS BEING SENT TO:** 1. **Mr Tim Higginson, Chief Executive University Hospital Lewisham, Lewisham High Street, London SE13 6LH** 2. **Professor Sir Bruce Keogh, National Medical Director NHS England, NHS England, PO Box 16738, Redditch, B97 9PT** 3. **The Secretary of State for Health, Rt. Hon Jeremy Hunt, Richmond House, 79 Whitehall, London SW1A 2NS** 4. **[redacted] Assistant Director of Investigations GMC, GMC, Fitness to Practice Directorate, Manchester Office, 3 Hardman Street, Manchester M3 3AQ**
1	**CORONER** I am Andrew Harris, senior coroner for the jurisdiction of London Inner South
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 25th November 2008, I opened an inquest into the death of Thomas Warren, case ref 3092-08 (JB), date of birth 4th October 1998, date of death 19th November 2008. The inquest was heard from 11th to 15th August 2014. The conclusion of the inquest was given by a narrative verdict below.
4	**CIRCUMSTANCES OF THE DEATH** Tom was prescribed for pain associated with cerebral palsy a 25 microgram patch of Fentanyl in an A&E department, which was administered at 20.00 hours on 17th November 2008. He developed symptoms of drowsiness, sickness, drinking a lot and feeling hot and cold. His parents were waiting for an OP consultation with his consultant on 21st. He arrested at about 08.45 on 19th and advanced life support was provided in a timely manner by ambulance and hospital staff, but he died without regaining consciousness at 15.02. The failure of the prescribing doctor to admit Tom to hospital, having decided to prescribe an opiate drug to a small opiate naïve child, outside its licence, amounted to neglect. Opportunities were missed for the dispensing of the drug by pharmacy to be stopped, if Trust procedures and guidance were properly followed, and for giving Tom's parents adequate information to monitor the effects of the drug.
5	**CORONER'S CONCERNS** It was reported that the prescribing doctor was recruited as a locum Paediatric Registrar one day before this incident, through a recruitment agency. There appeared to be no requirement by the employing NHS Trust for the agency to make checks on registration or fitness to practice, although the medical director assumed that this was performed. The predecessor to Lewisham and Greenwich Trust (Queen Elizabeth Hospital NHS

Trust) "The Trust" checked that there were no restrictions or conditions placed on practice by the GMC, which there were not. A reference was obtained from an employer some months earlier in Canada, which reported no concerns about fitness to practice. Unknown to the Trust the doctor had been employed in the meantime in New Zealand, where it was reported that concerns were also raised and an investigation begun. Also unknown to the Trust, the doctor had been referred for NCAS assessment from an NHS Trust in Wales in 2007. Concerns centred on his role as team leader failing to carry out adequate supervision and possible deficits in communication skills. The NCAS assessment was not carried out as the doctor left NHS employment and went to New Zealand in January 2008. The Welsh Trust reported the departure of the doctor abroad in December 2007 but not that the NCAS assessment had not been completed until 2009. Subsequent to this death the GMC placed conditions on his registration and then accepted voluntary erasure from the register. The Trust carried out no interview with the locum doctor before he began work (which would not be feasible in filling short notice vacancies), although the consultant to whom he was to be accountable met him.

The former Trust medical director gave evidence and agreed that there was a lacuna in the system which created potential risks to lives and advised that it would be feasible for a consultant to ask each new locum a question about previous fitness to practice concerns or NCAS referral, and that such an initiative would reduce the risks. He also pointed out that revalidation would offer more reassurance in future, but that this process operated over a number of years and would not necessarily provide and assurance at short notice for prospective employers of locums from abroad or with long gaps between UK jobs.

Submissions were received that the problem was a complex national one and that this report should not be confined to the local NHS Trust.

The **MATTERS OF CONCERN** are as follows. –

(1) There does not appear to be clarity as to who or which organization should enquire into previous fitness to practice concerns and referrals to NCAS (or successor organization) which have not led to restrictions or conditions of registration by the GMC when locum doctors are being recruited by an Agency at short notice by prospective NHS Trusts. In this case it appears that neither the Recruitment Agency nor Trust nor consultant asked the doctor before his employment began.

(2) There are particular difficulties with securing a complete sequence of employment and the associated references and confirmation about concerns for fitness to practice of long term locum doctors who may have gaps between jobs or worked abroad. Thus serious concerns about practice may have existed but not come to notice of the Agency or prospective employing NHS Trust.

(3) Crucial information was held by the GMC about concerns about this doctor's fitness to practice, including his referral to NCAS. This information was not available to those enquiring about his fitness to practice at a subsequent time. Nor was any provisional condition placed on his registration, having learnt that he was leaving the NHS so that the NCAS assessment was at risk of being in abeyance.

(4) There did not appear to be any regulatory mechanism for monitoring or reviewing cases where the doctor no longer works for the Trust where a remediation referral was made and NCAS (or other body) assessment is not completed, before subsequent locum employment. Revalidation requirements might not be an effective mechanism for employment of short notice locum vacancies.

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ACTION SHOULD BE TAKEN

(1) The findings of this inquest and Concern (1) above is brought of the attention of Lewisham and Greenwich NHS Trust to consider and, if appropriate, take action in

	relation to changes in recruitment policy or practice. The findings of this inquest and Concerns (1) (2) (3) and (4) above are brought to the attention of the Department of Health, NHS Medical Director and General Medical Council to consider, and if appropriate, take action which may reduce the risks of such an incident recurring.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **Monday, October 13th 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: [redacted] of Powell & Co (Solicitors for family) [redacted] (Solicitor for prescribing doctor) [redacted] of Glassbrooks (Solicitor for [redacted] the pharmacist) [redacted] and [redacted] (Solicitor for Lewisham and Greenwich NHS Trust) [redacted]. I have also sent it to [redacted] former medical director of the Trust, 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. If you would like further information about the case, please contact my officer, [redacted]
9	**[DATE]** 19th August 2014 **[SIGNED BY CORONER]**