REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr. John Adler Chief Executive University Hospitals of Leicester NHS Trust**
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire 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 30th June 2014 I commenced an investigation into the death of Michael Andrew Pollard, age 49. The investigation concluded at the end of the inquest on 5th March 2015. The conclusion of the inquest was Michael Pollard developed a duodenal ulcer from the repeat prescriptions of naproxen, provided by his general practitioners to give pain relief from osteoarthritic knee pain. NICE guidelines were not followed to also prescribe a Proton Pump Inhibitor to protect against gastric erosion. He collapsed at home on 23 June and was admitted via ambulance to the Emergency Department at Leicester Royal Infirmary, where an upper gastro-intestinal bleed was diagnosed and the protocol response commenced. Due to delays in escalation to senior colleagues, no early involvement of Intensive care and inadequate resuscitation with blood products, Michael became unresponsive before an endoscopy was arranged and died from massive haemorrhage several hours later on 24 June 2014. Cause of death 1a Massive upper gastro-intestinal haemorrhage 1b Bleeding chronic duodenal ulcer 1c Non-steroidal anti inflammatory drug treatment for knee pain
4	**CIRCUMSTANCES OF THE DEATH** See above
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. – During the night that Michael died, it was necessary to contact the on call GI bleed Consultant to discuss the need for an emergency endoscopy. This is accomplished via the hospital switchboard. The rota held by the switchboard staff was out of date, and

	they called a Consultant who was not on call and was on leave, travelling to the airport at the time. Time was lost in identifying the appropriate Consultant. I was advised that the Trust have not yet resolved a new system to avoid such difficulties in the future. In my opinion the following matters need to be considered (1) The on call rota must be up to date, accessible by both switchboard and those clinicians who need access to it (2) Any amendments must only be made centrally to a single point to avoid any discrepancies between previous rotas and the current rota (3)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 1 May 2015. 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] – brother of the deceased [redacted] – Holly Lodge Court Care Home [redacted] – GP 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	**[DATE]** 5 March 2015 **[SIGNED BY CORONER]** [redacted]