

## CLAIRE BALYSZ Assistant Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	Ms Nerissa Vaughan
	Chief Executive
	The Great Western Hospital NHS Foundation Trust
	Marlborough Road   Swindon
	SN3 6BB
1	CORONER
	I am CLAIRE BALYSZ, Assistant Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
	http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
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	On 17/06/2014 I commenced an investigation into the death of Robin Keith Brett, 18 . The
	investigation concluded at the end of the inquest on 22 December 2015. The conclusion of the inquest was Robin died from natural causes contributed to by neglect.
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4	CIRCUMSTANCES OF THE DEATH
	Robin was an 18 year old man who was born with congenital adrenal hyperplasia. This
	necessitated daily steroid replacement with a need to supplement the daily dose with IV steroids if he became unwell.
	He was admitted to the Great Western Hospital on 13 June 2014 with history of severe constipation and in an addisonian crisis. This was initially treated appropriately but he was not
	given the regular steroids that had been prescribed by the doctors. This was an error.
	When he died at 0430hrs on 14 June 2014 he had not had any steroids since 1200 hrs on 13
	June 2014. This significantly weakened his ability to cope with the strain the constipation put on his body.
	The evidence that I heard at Inquest showed that any patient on long term steroids for whatever
	reason must not have their steroids stopped suddenly, if they do there is a likelihood of an
	addisonian crisis and death.
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

This patient was prescribed steroids appropriately but the nursing staff failed to notice a dose of steroids had been missed. There is no system on the paper drug chart or the electronic prescribing system for alerting medical staff to patients being on long term steroids. 6 **ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. YOUR RESPONSE 7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 07 March 2016. 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. **COPIES and PUBLICATION** 8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18) at Swindon Local Safeguarding Children Board, Civic Offices, Euclid Street, Swindon SN1 2JH I have also sent it to Regional Medical Director, NHS England South, Bewley House, Marshfield Road, Chippenham, Wiltshire SN15 1JW Mr David Behan CBE, Chief Executive, Care Quality Commission, Citygate, Gallowgate, Newcastle upon Tyne NE1 4PA 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. 9 Dated 11 January 2016 Signature Assistant Coroner for Wiltshire and Swindon