## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Alwen Williams, Chief Executive, Barts Health, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB** |
| 1 | **CORONER**<br><br>I am Nadia Persaud, Senior Coroner for the Coroner area of East London |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On the 15th May 2014, I commenced an investigation into the death of Mr Devindar Lal Seth. The investigation concluded at the end of the Inquest on the 23rd February 2016. The conclusion of the Inquest was a narrative conclusion:<br><br>*Mr Seth suffered a fractured hip following a fall at his home on the 14th July 2013. He was admitted to Newham General Hospital where he underwent a dynamic hip screw procedure. Post-operatively, his pain was managed with opiate medication. He showed signs of opiate accumulation from the 19th July 2013. This was not identified or addressed until family members raised the alarm on the 23rd July 2013. When the opiate toxicity was identified, Mr Seth was transferred to ICU for close monitoring. He suffered aspiration on the ICU at around 18:50 on the 24th July 2013. Ventilation was required at this time, to robustly protect his airway. Ventilation was not carried out promptly after the aspiration and Mr Seth suffered a cardiac arrest at 23:45. Prompt ventilation following the aspiration at 18:50 on the 24th July 2013, would have prevented the cardiac arrest and his death on the 24th August 2013 would have been avoided.* |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Seth was a 94 year old gentleman who suffered a fall at his home on the 14th July 2013. He was admitted to Newham General Hospital in the early hours of the 15th July 2013 and underwent surgery to repair a fractured hip, on the 16th July 2013.<br><br>Post-operatively, Mr Seth's pain was initially managed with an epidural. During the period in which the epidural was in situ, he underwent close observations. The epidural was removed on the 18th July 2013 at 08:15. Following the removal Mr Seth suffered from pain and opiate medication was introduced in the form of oromorph and codeine. He had also received fentanyl via the epidural.<br><br>Mr Seth underwent 4-6 hourly observations from the 18th July to the 21st July 2013. [redacted] (consultant physician) confirmed that having reviewed the notes it was apparent that Mr Seth was suffering from opiate toxicity from the 19th July 2013. |

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| | Members of the family recognised the signs of opiate toxicity (excessive drowsiness and pinpoint pupils) and raised the alarm with hospital staff. Following this a review took place by the critical care outreach team and Mr Seth was transferred to ITU.<br><br>Administration of naloxone resulted in an improvement to Mr Seth's condition, therefore confirming the opiate accumulation.<br><br>Mr Seth suffered an episode of aspiration on the 24th July 2013 at 18:50. Ventilation was not carried out in time and he suffered a cardiac arrest at 23:45 on the 24th July 2013.<br><br>Following the cardiac arrest Mr Seth deteriorated as a result of both sepsis and multi-organ failure. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>During the Inquest I heard evidence in relation to the risks of orthogeriatric patients being placed on opiate medication. I was informed that these risks include slow metabolism of these drugs (particularly in the elderly), constipation, confusion, hallucinations, respiratory depression and excessive drowsiness.<br><br>There is no indication within the medical records that the side effects from the opiate medication upon Mr Seth were considered by the ward staff and his care plan adjusted accordingly.<br><br>It was a family member who raised the alarm regarding opiate toxicity, based upon the pinpoint pupils and excessive drowsiness.<br><br>The alarm was raised by the family member on the 21st July 2013. [redacted] confirmed that there was evidence of opiate accumulation from the 19th July 2013.<br><br>During the course of the evidence, it was confirmed that there is no clear guidance available to ward staff on the risk of opiate medications in orthogeriatric patients and side effects to look out for.<br><br>I have been provided with the WHO Analgesic Ladder and the Guidelines for Acute Pain Management in Adults. The guidelines provide substantial amounts of information in relation to the contra-indications of NSAIDs. The only information relating to opioids in the Guidelines is that regular opioids can cause constipation. It is clear that none of the ward staff in this case recognised the effect that the opiate medication was having upon Mr Seth and I consider that it would be helpful for easily accessible guidance to be available for both nursing and medical staff. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE** |

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| | You are under a duty to respond to this report within 56 days of the date of this report, namely **20th April 2016**. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to [redacted] (son) and [redacted] (son). I am also forwarding a copy to the Care Quality Commission and to [redacted] (Director of Public Health).<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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]** 26.2.16 **[SIGNED BY CORONER]** |