## 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. **Marcel Levi, Chief Executive, University College London Hospitals NHS Foundation Trust, 235 Euston Road, London. NW1 2BU. (UCLH)** |
| 1 | **CORONER**<br><br>I am R Brittain, assistant coroner, for Inner North 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. |
| 3 | **INVESTIGATION and INQUEST**<br><br>Michael Brennan died on 24 October 2016, aged 80. The inquest into his death concluded on 17 March 2017. Mr Brennan died from the consequences of small cell lung carcinoma. The conclusion of the inquest was narrative (see attached). |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Brennan began coughing up blood in early 2016. He had a background history of cigarette smoking and had been diagnosed with chronic obstructive pulmonary disease. His symptoms were investigated by chest x-ray and subsequently by CT scan. A repeat scan demonstrated a persistent area of concern. Before further investigations could be undertaken he was admitted to Whittington Hospital and treated for a serious infection.<br><br>In order to investigate the underlying cause of his symptoms a bronchoscopy was performed, after his condition had somewhat improved. During this procedure a mass was noted which was felt likely to be a lung cancer. This lesion started to bleed and was treated with the available methods of cold saline and adrenaline washes. These techniques appeared to improve the situation but the clinician who undertook the bronchoscopy was concerned by the extent of the bleeding and referred Mr Brennan to UCLH for interventional bronchoscopy.<br><br>This procedure could not be undertaken immediately as it is only performed during daytime theatre lists. The doctor to whom Mr Brennan had been referred at UCLH advised that, should the patient deteriorate overnight, he should be referred to cardiothoracics at the Westmoreland Street hospital (a satellite hospital of UCLH).<br><br>That evening the team caring for Mr Brennan at Whittington Hospital did refer Mr Brennan, as advised, with concerns regarding his condition. Unfortunately no beds were available at the Westmoreland Street hospital. Mr Brennan's condition initially stabilised but subsequently deteriorated to such a degree that admission to ITU at Whittington Hospital was required.<br><br>He was ultimately transferred to UCLH ITU for consideration of further treatment but this |

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| | was not felt to be in his best interests and he died some days later. |
| 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>(1) It was clear that significant concerns were raised regarding the extent of the bleeding which followed Mr Brennan's bronchoscopy. This was acknowledged to require expert input and transfer to UCLH. A plan was put in place to effect this, with a backup of more immediate transfer, should he deteriorate.<br><br>I am concerned that this backup plan relied on the availability of a bed at a satellite hospital, which was ultimately not available when it was required. This raises the concern that the bed status for the Westmoreland Street hospital was not known to the clinicians when this plan was devised. It is possible that future deaths could occur in similar circumstances if there is not a system in place to inform clinicians of the current bed status for the Trust's multiple sites. |
| 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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 May 2017. 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 the following: (a) Mr Brennan's family (b) The Care Quality Commission (c) The Whittington Hospital.<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 | **27/3/17**<br>**Assistant Coroner R Brittain** |