Ms N J Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Dr Sewa Singh** Medical Director, Doncaster Royal Infirmary, Armthorpe Road, Doncaster
1	**CORONER** I am Ms N J Mundy, Senior Coroner for South Yorkshire (East District)
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** On 25/03/2017 I commenced an investigation into the death of James Robert Quinton, 42 . The investigation concluded at the end of the inquest on 30 January 2018. The conclusion of the inquest was a Narrative conclusion: James Robert Quinton collapsed on 14 March 2017 due to a combination of a ruptured spleen and methadone and heroin ingestion. Mr Quinton failed to respond to extensive resuscitation and supportive measures and he died in the Doncaster Royal Infirmary later that day. The cause of death was 1a. Splenic rupture and combined morphine and methadone toxicity 2. Rivoroxaban therapy
4	**CIRCUMSTANCES OF THE DEATH** James Quinton had a known history of chronic drug and alcohol abuse. His partner [redacted] had been in a relationship with him for 12 years and has no knowledge of him having ever had any employment. He had a medical history of alcoholic liver disease, intravenous drug misuse, hepatitis C, epilepsy, previous DVT, on rivaroxaban, schizophrenia. He was admitted to DRI A&E at 02:30 hrs with a presenting history of 1 week vomiting blood, 1 day abdominal pain. He had been found unresponsive on the bathroom floor collapsed. On admission he was unresponsive - Investigations commenced -Bloods were taken - INR 3 - given vitamin K to reverse. Acidotic PH6.8, lactate greater than 20. 03:15 hrs cardiac arrest - arrest call - ALS - adrenaline, noradrenaline given. Femoral line put in place, sodium bicarbonate and glucose given. ROSC GCS low - pupils remained fixed and dilated. CT abdomen results - query splenic bleed. He was transferred to ICU - reviewed and discussions held with NOK. Decision due to significant Co-morbidities and poor status it was the opinion of the physicians that he would gain no benefit from any surgical intervention. Active treatment was withdrawn and he died on 15/03 at 14:26 hrs. I have spoken to Kelly Coates (partner) and she informs that the last time the deceased used illicit drugs was on the morning of Monday 13th March (heroin). She states that over the previous 7 days he had been unwell periodically vomiting.
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. –

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	(1) During the course of the evidence it became clear that the poor quality nursing notes and the lack of information of the observation chart made it difficult for the reviewing Consultants to get a clear picture of events that had been occurring. Clearly poor record keeping has significant implications for patients. (2) Furthermore, during the course of the resuscitation a decision was made for Mr Quinton to be given 4 mgs of Noradreneline. This was to be given as an infusion. Unfortunately, this was actually given as a 4 mg iv bolus. Although the records suggest this did not have a detrimental effect on Mr Quinton (his blood pressure had been exceptionally low) this clearly could be highly significant for other patients. It also raises the question of other patients being given either the wrong drug or the wrong amount of drug or the wrong method of administration when the procedure for drugs to be prescribed in this scenario is on a verbal basis only. It would seem sensible to have some checking procedure by the person administering the drugs checking with the person who had prescribed it to make sure their understanding is correct. From the evidence I heard it seems there are no such procedures in place.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Dr Sewa Singh 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 19 April 2018. 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] 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 22 February 2018 Signature_____ Senior Coroner for South Yorkshire (East District)

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