REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Meghana Pandit Medical Director University Hospital Coventry and Warwickshire NHS TRUST** **2.**
1	**CORONER** I am Andrew Cox, Assistant Coroner, for the coroner area of Worcestershire
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** In August 2018 an inquest was opened into the death of Mr Taylor who died on 31 July 2018. The inquest concluded at a hearing on 31 October 2018 where it was found that Mr Taylor had died as the result of an accident. The cause of death given at inquest was: 1a)Sepsis; 1b) chest infection; 1c) head injury II) chronic obstructive pulmonary disease
4	**CIRCUMSTANCES OF THE DEATH** On 27 July 2018 Mr Taylor suffered a fall at his home address and struck his head. He was taken to the Alexandra Hospital where a CT of his head revealed a large acute haematoma. After management of his condition and a further CT scan he was transferred to your Trust in the early hours of 28 July 2018. Following his admission it was noted that Mr Taylor displayed signs of agitation and tremors/seizures. It was felt that this was likely to be related to alcohol withdrawal. The doctor reviewed the Trust's protocol the management of such patients and, in error, prescribed and administered Diazepam. On 29 July 2018 Mr Taylor suffered a respiratory arrest. He was given an antagonist and recovered promptly to his pre-arrest condition. Sadly, Mr Taylor developed a chest infection and, despite treatment, subsequently deteriorated and died in the Trust on 31 July. One of the matters investigated at the inquest was whether, as a consequence of the respiratory arrest, Mr Taylor had aspirated. As a matter of fact it was found that the aspiration had occurred at the time of the original fall.
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. – (1) I heard in evidence from Mr Young, the Trust's Clinical Director who had carried out a Root Cause Analysis. I heard also from [redacted] one of the Trust's consultant neurosurgeons. Both consultants expressed their belief that neurosurgical patients of this nature required additional support from their consultant physician colleagues. I was told that this has been an issue for some time and remained unresolved. In particular, there was concern that a junior neurosurgical doctor was left to implement an alcohol withdrawal regimen. I was told that these difficulties are not confined to patients who are admitted with alcohol-related issues but extend across the whole range of neurosurgical patients who require medical input. (2) I was told that the alcohol withdrawal protocol was difficult to understand. This resulted in the doctor prescribing diazepam when Lorazepam should have been used. I was told and shown an action plan that the Trust intends to implement to improve the process. (3)
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. I would be grateful if you would review whether there is adequate support for neurosurgical patients who also have medical co-morbidities. If there is not, I would be grateful if you would consider how that situation may best be addressed
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th December 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 family of the deceased. I am also under a duty to send the Chief Coroner a copy of your formal 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	**Signed** ---------- **A J Cox** **1st day of November 2018** **HM Assistant Coroner**