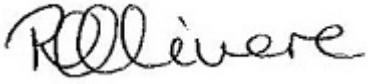
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Rebecca Ollivere, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 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** On 24 June 2021, I commenced an investigation into the death of Christopher COLLINSON. The investigation concluded at the end of the inquest on 26th October 2021. The conclusion of the inquest was; Natural causes
4	**CIRCUMSTANCES OF THE DEATH** Christopher Collinson was admitted to MAU at Birmingham Heartlands Hospital on 14th June 2021 with suspected DVT and PE. He arrived at the hospital at 13.28, however was not clerked by a Doctor until 21.33. The reason given for this was that the department was highly pressured on this date, and although a Junior Doctor had assigned the case to them by "clicking", that Doctor had not in fact been able to see Mr Collinson. He did not "unclick" the patient and therefore other Doctors who may have had capacity were not aware that Mr Collinson had not been seen. When Mr Collinson was seen by a Doctor, the Doctor prescribed a prophylactic dose of Enoxaparin rather than the therapeutic dose which she had intended to prescribe. The reason for this was that the electronic prescribing system is a drop down box with confusing tables to select the medication. The Doctor was under pressure due to the busy department and accepted this was human error, having accidently selected the wrong one. I was also told that no secondary check "pops up" requiring the Doctor to check the selection and confirm that is the prescription that was intended. Mr Collinson, collapsed at 23.00 and suffered a cardiac arrest. 27 cycles of CPR were commenced and Thrombolysis given on the 11th cycle. Sadly, he could not be revived and he died at 02.14 on 15th June 2021. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Pulmonary Embolism** **1b Deep vein thrombosis** **1c** **II**
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. The current system for allocating patients requires a manual check to see whether a patient has actually been seen once they have been allocated. If they are not seen, there is currently no way of other clinicians being aware of that, and therefore patients could be left for long periods of time without having been assessed. 2. The current electronic prescribing system does not require a Doctor to perform a secondary check that they have selected the correct medication. I am concerned that it is all too easy to select the wrong medication, particularly when the department is busy and Doctors are under pressure. This could lead to fatal outcomes for patients if given incorrect medication.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd December 2021. 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:- Mr Collinson's Next of Kin University Hospitals Birmingham NHS Foundation Trust 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	**26 October 2021** Signature:  **Rebecca Ollivere** **Assistant Coroner for Birmingham and Solihull**