RESPONSE TO REGULATION 28 CORONER'S REPORT TO PREVENT FUTURE DEATHS

1	**THIS RESPONSE IS MADE ON BEHALF OF** University College London Hospitals NHS Foundation Trust
2	**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** This response follows a report by R Brittain, Assistant Coroner for Inner North London dated 7th May 2014
3	**INVESTIGATION AND INQUEST** The inquest in question relates to the death of Peter John BROOKES, who died at University College London Hospital on 27th August 2013. His inquest was commenced on 3 September 2013 and concluded on 30 April 2014. The conclusion of the inquest was narrative.
4	**CIRCUMSTANCES OF THE DEATH** Mr Brookes had a background medical history which included Parkinson's disease (PD) and ischaemic heart disease. He was admitted to University College Hospital (UCH) in early August 2013 for removal of a cancerous skin lesion. He was catheterised postoperatively. This resulted in some bleeding, which was thought to be resolving and the catheter was removed. The bleeding recurred, which resulted in a short readmission to UCH and warranted reinsertion of a catheter. Mr Brookes was admitted for a third time on 17 August after the catheter became blocked. During this admission there were issues regarding the sourcing and administration of Mr Brookes' PD medication, meaning that he did not receive his medication as prescribed. On 18 August Mr Brookes had a period of 'agitation' and rapid breathing, which the nursing staff felt warranted review by the ward doctors, although his symptoms did resolve after administration of pain relief. This review did not occur despite repeated requests from the nursing staff. I heard evidence that weekend ward rounds routinely take most of the day to complete, which might mean that the on call team were so busy that nonemergency reviews would not occur. In the morning of 19 August Mr Brookes suffered a respiratory arrest, which resulted in his admission to the Intensive Care Unit (ICU). Subsequent investigations demonstrated that Mr Brookes had suffered a heart attack. Whilst on the ICU it was discovered that one of the PD medication boxes (Amantadine) actually contained another medication, as a consequence of a dispensing error in the hospital pharmacy. There was no evidence that Mr Brookes had been administered the wrong medication. Mr Brookes developed bronchopneumonia and continued to deteriorate, despite ongoing medical treatment. He died on 27 August 2013.
5	**CORONER'S CONCERNS** As an organisation we are mindful of our duty to consider your report and indeed I have carried out a full review of the issues raised. I have sought advice from a number of areas, including the head of pharmacy and

	divisional clinical director for clinical support, clinical nurse specialist for Parkinson's Disease, a consultant neurologist and clinical leads and managerial staff for the Urology specialty. The **MATTERS OF CONCERN** are as follows. – (1) The administration of PD medication in hospital routinely does not follow patients' usual regimens and that this, in itself, could cause physiological stress and contribute to early death. It was not possible conclude that, on the balance of probabilities, this was the case in Mr Brookes death but it was clear that this was a continuing risk, which could result in future deaths. (2) The risks posed by the unavailability of doctors for nonemergency reviews, during weekend shifts, raises concern that future deaths could occur as a consequence. (3) The cause of the dispensing error, that resulted in the wrong medication being put in a box labelled as 'Amantadine', was not elucidated during the inquest and raises concern that future similar errors could recur, with potential for future deaths resulting.
6	**ACTION TAKEN/TIMESCALE**

(1) I heard evidence that the administration of PD medication in hospital routinely does not follow patients' usual regimens and that this, in itself, could cause physiological stress and contribute to early death. It was not possible conclude that, on the balance of probabilities, this was the case in Mr Brookes death but it was clear that this was a continuing risk, which could result in future deaths.

The Trust recognises the importance of ensuring medications, particularly those relating to PD and other time sensitive medication are taken in accordance with the patient's usual medication schedule. A key approach to this in the Trust's specialist PD area is through promoting and encouraging self medication where appropriate.

In order to ensure staff across the Trust are alerted to the critical importance of ensuring PD patients take their medication on time the following actions will be taken.

Action	Owner	Completion date
An item to be included in the July Quality and Safety newsletter.		July 2014
Link to Parkinson's Disease website and reference to 'Get it on time' video to be included in the Q&S newsletter.		July 2014
Awareness to be raised via the Trust Clinical Practice Facilitators forum.		August 2014

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(2) The risks posed by the unavailability of doctors for nonemergency reviews, during weekend shifts, raises concern that future deaths could occur as a consequence.

The Trust has systems in place for the provision of urgent and non urgent medical cover over the weekend period. For Urology in particular there is:

- A Urology ward Senior House Officer (SHO) post which provides essential cover for the elective wards (T6 and T10) from 8am – 5pm performing general duties and ward reviews.
- A surgical Senior House Officer (SHO) post which provides emergency surgical cover primarily to Accident and Emergency Department
- A Urology Specialty Registrar (SpR) who performs daily ward rounds on elective ward rounds accompanied by the ward SHO. The SpR works Saturdays and Sundays and is available on an on call mobile phone 24/7 and must be no more than 1 hour away from the hospital at any one time.
- An on call Urology consultant who provides support and advice as needed and attends the hospital when required.

The SHO is usually contacted via the hospital bleep system. However, If the nursing staff are unable to make contact via the bleep system for whatever reason (which was the situation which arose with Mr Brookes) they are advised to contact the medical staff via their mobile phones. A staff directory provided to the wards on a quarterly basis (most recently circulated in June 2014) contains numbers for clinical and managerial staff in the Urology specialty. If the SHO cannot be contacted nursing staff are instructed to escalate through the medical cover system to senior registrar and consultant level if necessary this would be supported by the ward sister or charge nurse for this area. At weekends the same escalation system would apply but with site practitioner available to support nurses escalating based in the operations centre rather than ward sister. During evenings (8.00pm – 8.00am) this process of escalation is managed by the hospital at night team service. A nurse unable to contact a Senior House Officer by bleep would escalate through the night triage system which is led by the night site practitioner based in the operations centre

The escalation process has recently been included in nursing staff local induction to ensure that all new starters are clear of the escalation process and where to access the staff directory which is saved on a shared server and physically stored in folders on the ward.

The system of cover was further strengthened in November 2013 by the introduction of an 'SpR of the week' on call rota rather than a 12 hourly rotation. The Urology SpR of the week is dedicated entirely to on call duties and is available for both ward and A&E patients at both weekends and during the week (8am – 8pm). This has reduced the number of handovers which is where there is the possibility of actions being missed.

A further action to raises awareness of escalation processes across the Trust will be undertaken via the July Quality and Safety newsletter.

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(3) The cause of the dispensing error, that resulted in the wrong medication being put in a box labelled as 'Amantadine', was not elucidated during the inquest and raises concern that future similar errors could recur, with potential for future deaths resulting.

The Trust recognises that medication errors relating to the prescribing, dispensing and administration of medications is a key risk facing all NHS Trusts. In recognition of this the Trust has an ongoing and comprehensive risk reduction programme in place. In relation to dispensing errors in particular there were a number of routine processes in place to minimise the risk prior to the error. These are:

- Independent double check in place for dispensed medicines.
- The majority of medications are stored in and dispensed from pharmacy robots to minimise picking errors
- Where packs are not able to be stored in the robot – similar looking/sounding drugs are stored in separate areas to try and avoid possible picking errors
- We use Tallman lettering (the practice of writing part of a drug's name in upper case letters to help distinguish sound-alike, look-alike drugs from one another in order to avoid medication errors)
- All dispensers are trained pharmacy technicians or assistants and complete dispensing logs during induction to ensure that they are competent in the dispensing process
- All checkers are pharmacists or qualified accredited checking technicians and have to complete checking logs to ensure competence
- Any dispensing/checking errors that leave the pharmacy department are thoroughly investigated
- All pharmacy incidents are reviewed at the pharmacy clinical governance meeting and actions plans monitored when appropriate

Following the error other changes have been implemented which further minimise the risk:

- A system of continuous monitoring of 'in process' dispensing errors (i.e. errors picked up at the checking stage) has been implemented. This data is reported and reviewed monthly for all dispensary areas and for all dispensing staff in the trust.
- Staff (both dispensers and checkers) involved in any errors that leave the department are required to complete reflective statements as to why they felt the error occurred and include self-reflection on lessons learnt to try and prevent a re-occurrence. They are also required to complete checking/dispensing logs to assess competency.
- Dispensing errors and any themes identified are shared with staff at dispensary meetings to raise awareness and share learning to avoid similar occurrences.

(4)	**THIS RESPONSE HAS BEEN PREPARED BY** Professor [redacted]
(5)	**DATE OF RESPONSE** 2nd July 2014