REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Chief Executive - University College London Hospitals NHS Foundation Trust**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
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** The investigation into the death of Umul Kelsum Anna AUDU, aged 25, was commenced on 23 October 2013 and concluded at the end of the inquest on 24 January 2014. The conclusion of the inquest was narrative [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Anna Audu was admitted to A&E at University College Hospital on 10 October 2013 with symptoms of headache and back pain. She was treated for both bacterial and viral illnesses, which resulted in her being prescribed a number of medications. She subsequently developed a rash, which rapidly progressed to Toxic Epidermal Necrolysis (TEN). The cause of this condition may have been an infection, or a medication that Miss Audu was prescribed. However, a definitive cause was not able to be elucidated at the inquest. The development of TEN necessitated Miss Audu's admission to the Intensive Care Unit (ICU), in an attempt to treat the organ failure and fluid/heat loss which results from this condition. Miss Audu underwent a CT and MRI scan on 15 October, which caused her to be away from the ICU for a period of three hours. Documentary evidence was presented at the inquest that there is no 'transport heater' available on the ICU to enable warming of patients whilst they are away from the unit. On Miss Audu's return from the imaging department she was hypothermic. Further evidence, presented in writing by the treating clinician, set out that this period of hypothermia did not result in any adverse consequences and did not therefore contribute to Miss Audu's death, when she succumbed to the effects of TEN on 20 October 2013.
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 lack of transport heater availability was not explained in the written evidence presented by the Trust. I did not judge it appropriate to adjourn the inquest in order to obtain further written or live evidence on this point, as sufficient information was available in order to conclude matters on 24 January 2014. However, it remains a concern that, in similar circumstances, the lack of transport heater could result in future patients becoming hypothermic on transfer, which might result in their death. As such, I am making this report in order that the Trust can respond to this concern.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the Trust, 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 24 March 2014. 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, Miss Audu's family and The Care Quality Commission. 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	**27 January 2014** **Assistant Coroner R Brittain**