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. **James Scott** **Chief Executive** **Royal United Hospital** **Combe Park** **Bath** **BA1 3NG**
1	**CORONER** I am Maria Voisin, Senior Coroner, for the area of Avon
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 4th February 2014 I commenced an investigation into the death of **Dorothy Joan ROBINSON**, aged **79**. The investigation concluded at the end of the inquest on 11th August 2014. The conclusion of the inquest was that the medical cause of death should be recorded as Ia Respiratory failure Ib Diffuse alveolar lung injury Ic Busulphan treatment for myeloproliferative disorder (thrombocythemia) II Pulmonary emboli and infection The conclusion I gave was accidental death contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mrs. Robinson had a disorder which required treatment and over the years she had at times received Busulphan for this. During 2006 she was seen by a [redacted] with difficulties breathing. [redacted] felt that her symptoms may be due to the Busulphan and he wrote a letter to her consultant advising that consideration should be given to using an alternative drug. Her consultant, [redacted] said that at the time in 2006 she saw the letter and she wrote on it. From 2006 to 2012 Mrs. Robinson did not receive Busulphan. In late 2012 she was again given Busulphan by [redacted] who said that in 2012 she had no recollection of the letter and if she had she would not have prescribed Busulphan. In December 2013 Mrs. Robinson's breathlessness became a concern, she developed pneumonitis due to the Busulphan she was admitted to hospital on 18th January severely unwell and sadly died on 27th January 2014. It is clear that the death was due to an adverse drug reaction causing the pneuomonitis It also appeared that there was a failure to remember the previous intolerance recorded in the records by the consultant when re-prescribing Busulphan or to consider why the drug had been previously stopped before re-prescribing it.

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. – During the inquest I heard evidence that there remains a risk of a prescribing error despite the steps taken by RUH to date. I have been advised that there is only one way to help prevent this and that is through the electronic prescribing system referred to in the Action Plan to the Root Case Analysis. I was not told an exact date when the system will be introduced only that there was an understanding that it may take up to two years. I would like to receive reassurance from the RUH as to the exact steps that are being taken in relation to installing this system or indeed any other system which can help prevent a prescription error. I was advised that the millennium system is not proposed to be used in this way Therefore in summary please advise of the steps planned to be taken to prevent a prescription error across the whole of the Trust in all areas of medicine due to a previous intolerance/reaction/allergy.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 Friday 10th October 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 and to the following Interested Persons – the family. 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	**13/8/14** **M. E. Voisin**