Regulation 28: Prevention of Future Deaths report

Ralph Stephen GOSLIN (died 21.06.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Corporate Medical Director** **University College London Hospitals NHS Trust** **University College Hospital** **2nd Floor Central** **250 Euston Road** **London NW1 2PG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 27 January 2014 I commenced an investigation into the death of Ralph Stephen Goslin, aged 40. The investigation concluded at the end of the inquest on 18 June 2014. The jury's determination made at inquest was by way of a narrative, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Mr Goslin was an inpatient at St Pancras Hospital on Montagu Ward, detained under Section 3 of the Mental Health Act. He suffered with schizophrenia and also epilepsy. He was found unresponsive in the bath on 21 June 2014, and died later that day in University College Hospital.

	The jury recorded his medical cause of death as: 1a seizure related death (seizure alone or with drowning) in epilepsy 1b grade IV glioblastoma
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 **MATTER OF CONCERN** for UCLH is as follows. 1. The junior doctor at St Pancras Hospital who first reviewed the UCH blood test result giving Mr Goslin's sodium valproate level as less than 3, did not realise that this was sub therapeutic, because the reference range was given as less than 100, rather than 50-100 as it is in some other hospitals. This meant that Mr Goslin's failure to take his anti epilepsy medication was not recognised as quickly as it could have been.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and 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 22 August 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] father of Ralph Goslin

	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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 25.06.14