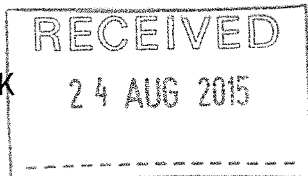


RECEIVED
24 AUG 2015

Brighton and Sussex University Hospitals
NHS Trust

Our ref: MK565/KK

20 August 2015

Headquarters
The Royal Sussex County Hospital
Eastern Road
Brighton
BN2 5BE

Tel: 01273 696955

Miss V Hamilton-Deeley
Her Majesty's Senior Coroner
For the City of Brighton & Hove
The Coroner's Office
Woodvale, Lewes Road
Brighton
BN2 3QB

Dear Miss Hamilton-Deeley

The Late Isaac Bahar, date of birth: 18.10.1941
NHS No: 623 012 4009

Thank you for your letter of 15th June 2015 and its enclosures, received on 19th June, and for drawing your concerns to our attention. We have not been able to identify any Trust member of staff called [redacted] but we have ensured that the matron with responsibility for all the Level 9a wards has had sight of your report and an opportunity to reflect on the matters you have raised. We too have given careful consideration to your letter. As you know, we are always willing to review our practices in this Trust, in order to identify improvements which can be made in the light of experience.

Mr Bahar was very unwell when he was admitted to the Royal Sussex County Hospital, and his prognosis was poor. However, we agree that it is wrong and unacceptable for any patient with chronic kidney disease, as suffered by Mr Bahar, to have codeine prescribed and administered to him. This was followed up with both the medical staff concerned - even though both happened to be locums, they had both worked continuously in the Trust for a considerable period; our investigations have not found any reason to believe that this acknowledged error arose from their locum status. They were both aware that codeine should not be prescribed in such circumstances.

While the consultant was not able to recall the particular circumstances of the ward round in which his plan included prescribing codeine for Mr Bahar, the more junior doctor who actually wrote the prescription is clear that it was and remains her routine practice to check renal function by looking at the relevant test results before writing any such prescription. She was mortified to discover that on this occasion she must have failed to do so. She could only hypothesise, and apologise profoundly, that on this occasion there must have been some interruption or other distraction which made her overlook what she is well aware is a vital step before any such prescription is written. A ward pharmacist routinely reviews prescription charts, and when she found this inappropriate prescription she immediately discussed it at the time with the team and crossed off the prescription less than 24 hours after it had been written.

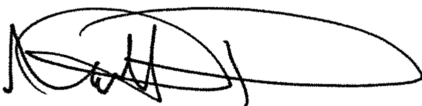
The Trust's lead pharmacist in patient safety carried out a detailed investigation of this matter. She found no evidence that there was a failure in knowledge or education, or any failure in selection or induction of locum staff, which caused or contributed to the medication being prescribed outside the Trust's recommended analgesia guidance. The British National Formulary (BNF) makes it clear that codeine and other opioid analgesics should be avoided or used with caution at reduced doses in patients with renal impairment.

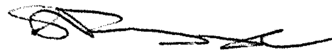
Codeine was also used on the gastroenterology ward where Mr Bahar was a patient to help reduce diarrhea, a common symptom for gastroenterology patients. The lead pharmacist has confirmed that she would not expect nurses to be aware of the nuances of codeine metabolism in patients with renal impairment, and there was therefore no reason for the nurses administering the prescription to query this prescription before administering it.

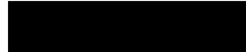
This incident, and the sad death of Mr Bahar, has been discussed in detail with both the general surgeons and the nursing team on Level 9a, as well as with the pharmacy team. As a direct result, the general surgeons decided that codeine should no longer be routinely available for them to prescribe. Discussions are continuing to seek a consensus as to whether the benefits of withdrawing codeine altogether from use within the Trust by other specialists would outweigh the associated disadvantages of such a step.

Thank you once again for raising this concern with us. Please pass on our sincere condolences to Mr Bahar's daughter and the family on their sad loss.

Yours sincerely







Matthew Kershaw
Chief Executive

Chief Nurse