VERONICA HAMILTON-DEELEY, LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
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Assistant Coroners
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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	THIS REPORT IS BEING SENT TO: **1. [redacted], Chief Executive, Brighton & Sussex University Hospitals NHS Trust** **2. [redacted], Chief Nurse, Brighton & Sussex University Hospitals NHS Trust** **3. [redacted], Ward Manager, Level 9a West Millennium Ward, Brighton & Sussex University Hospitals NHS Trust**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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** On 11th May 2015 I commenced an investigation into the death of Isaac Silas BAHAR. The investigation concluded at the end of the Inquest on 14th May 2015. The Narrative conclusion of the Jury Inquest was:- **Mr. Isaac BAHAR was a vulnerable man living at Hyman Fine House. He had a diagnosis of Bi-polar affective disorder. His mental health deteriorated requiring voluntary admission to Mill View Hospital.** **On the 10th of November, during the early hours Mr. Isaac BAHAR suffered an unwitnessed fall. At approximately 9:00am on the 10th November emergency services were called and Mr. BAHAR was admitted to The Royal Sussex County Hospital, where following examination it was determined that he had**

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	sustained four fractured ribs and a traumatic pneumothorax for which he was treated. **His medical records stated that he had stage four chronic kidney disease. As part of his treatment he was prescribed codeine by the locum doctors on duty at that time, which was in contravention of the national and local guidelines. The prescription was reviewed by the pharmacist the next day and was withdrawn. Mr. BAHAR appeared to stabilise but suddenly deteriorated on the 13th of November. He was tended by the Medical Emergency Team at which stage the decision was taken to administer Naloxone to counter the toxic effects of codeine to which he partially responded. However, his condition continued to deteriorate rapidly, resulting in his death.** **It was later discovered by the pathologist that Mr. BAHAR had chronic obstructive pulmonary disease, which was deemed to be a contributory factor in his death.**
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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: Mr. Bahar was admitted to the Royal Sussex County Hospital on 10th November 2014 with pneumothorax due to fractured ribs. He was treated urgently and appropriately until his analgesia. He was a man with known Stage 4 Chronic Kidney Disease, yet in breach of the hospital's own policy and in breach of national guidance he was prescribed and given four doses of Codeine over 18 hours. Although this was stopped by the ward Pharmacist as soon as she was able to review his drug chart, Mr. Bahar collapsed with severe opiate/opioid toxicity 30 hours later and died just under three hours after the collapse. The Jury at his Inquest found this error to be one of the causes of his death

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	The Codeine was directed by a locum surgical consultant and the fatal error was compounded when a locum junior doctor wrote up the Codeine in Mr. Bahar's drug chart. Their locum status must be relevant and if the Trust employs locum staff they must satisfy themselves that those staff are aware of such guidance particularly in such a common scenario (elderly patient with Chronic Kidney Disease needing analgesia). The Trust is responsible for ensuring their patients are in safe hands. Senior nurses should also be aware of such common pitfalls. They would then be in a position when caring for their patients to pick up anomalies. This is a serious failing and must be urgently addressed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 3rd September 2015. 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 1. [redacted] Medical-Legal Services Manager, Brighton & Sussex University Hospitals NHS Trust, 2. [redacted] Chair, Brighton & Sussex University Hospitals NHS Trust 3. Secretary of State for Health, Department of Health 4. Simon Stevens, Chief Executive NHS England 5. National Patient Safety Agency 6. [redacted] Director of Public Health, Brighton & Hove Clinical Commissioning Group 7. [redacted] Director for Clinical Quality & Primary Care, Brighton & Hove Clinical Commissioning Group

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8. [redacted] Acting Deputy Chief Pharmacist, Brighton & Sussex University Hospitals NHS Trust,
9. [redacted] Specialist Clinical Pharmacist, Brighton & Sussex University Hospitals NHS Trust
10. [redacted] SHO, ITU, Brighton & Sussex University Hospitals NHS Trust
11. [redacted] Consultant Intensivist, Chief of Safety & Quality, Brighton & Sussex University Hospitals NHS Trust

I have also sent it to:-

1. [redacted]
2. Colm Donaghy, Chief Executive, Sussex Partnership NHS Foundation Trust
3. [redacted] Legal Support Manager, Sussex Partnership NHS Trust
4. [redacted] Patient Safety Ombudsman, Brighton & Sussex University Hospitals NHS Trust

Who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response.

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	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	**Date:** **15th June 2015** **SIGNED BY:** [redacted] **Senior Coroner, Brighton and Hove**