RESPONSE TO REGULATION 28 CORONER'S REPORT TO PREVENT FUTURE DEATHS

1	**THIS RESPONSE IS MADE ON BEHALF OF** University College London Hospitals NHS Foundation Trust
2	**REGULATION 28 REPORT** **THIS REPORT IS BEING SENT TO:** Marcel Levi, Chief Executive, University College London Hospitals NHS Foundation Trust, 235 Euston Road, London. NW1 2BU. (UCLH)
3	**CORONER** I am R Brittain, assistant coroner, for Inner North London
4	**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.
5	**INVESTIGATION AND INQUEST** Michael Brennan died on 24 October 2016, aged 80. The inquest into his death concluded on 17 March 2017. Mr Brennan died from the consequences of small cell carcinoma. The conclusion of the inquest was narrative.
6	**CIRCUMSTANCES OF THE DEATH** Mr Brennan began coughing up blood in early 2016. He had a background history of cigarette smoking and had been diagnosed with chronic obstructive pulmonary disease. His symptoms were investigated by chest x-ray and subsequently by CT scan. A repeat scan demonstrated a persistent area of concern. Before further investigations could be undertaken he was admitted to Whittington Hospital and treated for a serious infection. In order to investigate the underlying cause of his symptoms a bronchoscopy was performed, after his condition had somewhat improved. During this procedure a mass was noted which was felt likely to be a lung cancer. This lesion started to bleed and was treated with the available methods of cold saline and adrenaline washes. These techniques appeared to improve the situation but the clinician who undertook the bronchoscopy was concerned by the extent of the bleeding and referred Mr Brennan to UCLH for interventional bronchoscopy. This procedure could not be undertaken immediately as it is only performed during daytime theatre lists. The doctor to whom Mr Brennan had been referred at UCLH advised that, should the patient deteriorate overnight, he should be referred to cardiothoracics at the Westmoreland Street hospital (a satellite hospital of UCLH). That evening the team caring for Mr Brennan at Whittington Hospital did refer Mr Brennan, as advised, with concerns regarding his condition. Unfortunately no beds were available at the Westmoreland Street hospital. Mr Brennan's condition initially stabilised but subsequently deteriorated to such a degree that

	admission to ITU at Whittington Hospital was required. He was ultimately transferred to UCLH ITU for consideration of further treatment but this was not felt to be in his best interests and he died some days later.
7	**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. – It was clear that significant concerns were raised regarding the extent of the bleeding which followed Mr Brennan's bronchoscopy. This was acknowledged to require expert input and transfer to UCLH. A plan was put in place to effect this, with a backup of more immediate transfer, should he deteriorate. I am concerned that this backup plan relied on the availability of a bed at a satellite hospital, which was ultimately not available when it was required. This raises the concern that the bed status for the Westmoreland Street hospital was not known to the clinicians when this plan was devised. It is possible that future deaths could occur in similar circumstances if there is not a system in place to inform clinicians of the current bed status for the Trust's multiple sites.
8	**ACTION TAKEN/TIMESCALE** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
9	**RESPONSE** The bed status and acceptance of referrals is covered in the trust policy – 'Management of patient flow – UCH Tower' for the UCH site and in similar policies for the other hospitals. This policy and the policy for the National Hospital of Neurology and Neurosurgery are in the process of being extensively reviewed in preparation for the implementation of an electronic coordination centre. This full review will be complete by September 2017. However we will amend it by the end of May 2017 to take account of the normal practice with respect to Westmoreland Street Hospital (WMS) beds which is twice daily updates on the WMS bed state being sent to the main hospital. Regarding critical care specifically, this works separately as referrals are considered by the senior doctor on site who can visualise the number of beds directly. If a referral is accepted they will inform the referring hospital who will arrange transport. WMS critical care unit use the same system as UCH critical care which is an electronic whiteboard which all site managers have access to – this will also be incorporated into the revised policy by the end of May 2017 so that practice is reflected in the written policy. For future bed management UCLH is currently implementing an electronic coordination centre in conjunction with TeleTracking. This will provide real-time data on bed capacity and patient demand and allow better management of the flow of patients through University College Hospital, National Hospital of Neurology and Neurosurgery and Elizabeth Garrett Anderson Wing. This means we can reduce delays in patient care and prevent cancellations of procedures at short notice as a result of not being assured that there is a bed for the patient to

	move in to. The coordination centre programme will be implemented using a phased roll-out and the first elements of the programme will go live in November 2017. The remaining sites of the trust are not included in this plan as they will move to new buildings within UCH Campus during building phases 4 which will include WMS (due 2020) and phase 5 (due 2019), therefore investing in the infrastructure within existing buildings is not financially prudent
10	**THIS RESPONSE HAS BEEN PREPARED BY** [redacted] Director for Quality and Safety
11	**DATE OF RESPONSE** 19 May 2017