NHS England

Professor Sir Bruce Keogh
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Mr David Heming
Coroner's Office,
Lawrence Court,
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Huntingdon,
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14th November 2017

Dear Mr Heming,

Re: Regulation 28 Report to Prevent Future Deaths – Sam Crick (died 04.03.2016)

Thank you for your Regulation 28 Report dated 2 August 2017concerning the death of Mr Crick on 4th March 2016. Firstly, I would like to express my deep condolences to Mr Crick's family.

The regulation 28 report concludes Mr Crick's death was a result of complications of raised intracranial pressure resulting from the late failure of an endoscopic third ventriculostomy. It was also concluded that a timely neurological intervention would have saved his life.

Following the inquest you raised concerns in your Regulation 28 Report to NHS England regarding the administration of opiates in someone with raised intracranial pressure and/ or an altered level of consciousness. Specifically, you are concerned that the opiate could act as a respiratory depressant leading to raised levels of carbon dioxide in the blood which could ultimately be fatal and, therefore, constitutes a risk of future deaths.

As a result, NHS England has given careful consideration to your recommendation and has sought professional advice from the Society of British Neurological Surgeons (SBNS). They have discussed this case in greater detail at their Council meeting and agreed that it would be beneficial to increase awareness among professionals on the use of opiate medication in patients with intracranial pressure.

Consequently, the SBNS have recommended the most effective solution to address these concerns would be for the NHS to issue a guidance statement jointly with the Royal College of Emergency Medicine. This will focus on treating patients with raised intracranial pressure and urge extreme caution in relation to the use of opiates. NHS England will work with these professional bodies to help produce and distribute this statement nationally within the next 6 months.

We are pleased to learn Luton and Dunstable hospital have since developed a local standard operating procedure (SOP) for such cases. However, further work would be needed to validate their guidance to determine if this guidance should be adopted nationally. We believe that rather than sharing this SOP, the above suggested guidance will have a greater impact across the NHS by effectively reaching the right professions with a national statement.

NHS England acknowledges the concerns you have raised with the Trust and we will seek their assurances that they have addressed such matters in line with the Serious Incident Framework. We will also suggest to the Trust that an independent review of the case management ought to be carried out as this would be helpful in understanding the failings in this case and to prevent any future deaths.

Thank you for bringing this important patient safety issue to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP
National Medical Director
NHS England