REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **Chief Executive of Oxford University Hospitals NHS Foundation Trust** **Chief Executive's Office** **Level 3, John Radcliffe Hospital** **Headley Way, Headington, Oxford, OX3 9DU.**
1	**CORONER** I am Mrs Heidi J. Connor, senior coroner, for the coroner area of Berkshire.
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** I conducted an inquest into the death of Saif Mubeen Hussain on 19th November 2021. I recorded a conclusion of suicide
4	**CIRCUMSTANCES OF THE DEATH** The family asked me to refer to the deceased as Saif during the inquest. I will respect that wish in this report. Saif Hussain was born on 22nd January 1998. He had no recorded mental health history. Tragically, for reasons unknown to family, he [redacted] in Bracknell, Berkshire on 3rd June 2021 and [redacted]. He was admitted to the John Radcliffe hospital later that day, but died there on 10th June 2021. His cause of death was polytrauma. For the absence of doubt, the issues raised below in relation to the hospital management are unlikely to have played a part in causing Saif's death, but I do consider that there is a risk of future deaths for other patients unless these issues are addressed. Saif was managed in the AICU from 4th to 7th June. On the 7th June, he was transferred from AICU to NICU. He had various infusions running, including a Heparin infusion. At the time of transfer, he was prescribed a dose rate of 1.4 ml/hour. Saif was also on a phosphate infusion, prescribed at 8.3 ml/hour. Whilst the prescribed doses remained the same, he was in fact administered a dose almost 8 times higher than that, namely 8.3 ml /hour. It seems likely that the rate prescribed for the phosphate infusion was mistakenly applied to Heparin. This matter has been investigated, and the trust has produced an excellent report. The evidence heard at the inquest, and within that report, show that: 1. Nurses working in a NICU do not routinely use anticoagulant medication. The nurses who started the wrong Heparin rate were not familiar with usual dosage rates.

	2. There were several nurses involved at that point, perhaps with a lack of ownership in terms of accuracy of the dose rate. This was also not double checked. 3. The Guardrails system (which would have prevented such an exceptionally high dose being administered) was switched off in order to allow the nurse/s to administer a rate of 8.3 ml/hour. 4. The systems in place at the time allow for the prescription rate and administration rate to be markedly different without that being flagged up. 5. Crucially, the hospital uses different computer systems in different parts of the hospital, to record patient records. The risks would clearly be much reduced, particularly for transfers within the hospital, by all departments being on the same system. We heard in evidence that the trust has always planned to consider amalgamation of the different IT systems. It is not for me to say which system they should or should not adopt. I accept that there may be advantages to the current system that were not explored during the inquest. I do however consider that there should be some focus on these issues within the trust, and an urgent review should be conducted.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. The trust should consider : 1. A single system for record keeping and monitoring. 2. How the system could incorporate appropriate limits on the administration of certain drugs within that system. 3. Whether software like Guardrails should be implemented more widely, and consideration given to when and how it is possible to override this, and how that should then be documented. 4. Adopting a system of flagging up where prescription and administration of drugs is different.
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 20 January 2022. 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 Saif's family. 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. I have also sent a copy of this report to the senior coroner for Oxfordshire, Mr Darren Salter.
9	**25 November 2021**  **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**