REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chris Bown, Interim Chief Executive, Barking, Havering & Redbridge University Hospitals NHS Trust**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner area of East London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 20th June 2019 I commenced an investigation into the death of Doris Daisy Laura Clark. The investigation concluded at the end of the Inquest on the 18th December 2019. The conclusion of the Inquest was the short form conclusion of "accident".
4	**CIRCUMSTANCES OF THE DEATH** Mrs Clarke fell in her home address on the 3rd November 2018. She remained on the floor for around 6 hours before paramedics were called. Paramedics attended and suspected that she had suffered a fractured neck of femur. The paramedics administered 5 mls (10 milligrams) of Oramorph at 15:40. A further 5 mls (10 milligrams) was administered at 15:50. Despite this administration of pain relief, Mrs Clark reported severe pain on arrival to hospital. She was seen by an A & E consultant who prescribed a further 10 milligrams of morphine to be administered intravenously. This further dose of morphine was administered at 17:58. It was not titrated, but was administered as an IV push. Following this administration, Mrs Clark was not monitored in accordance with Trust policy. Mrs Clark suffered a large vomit whilst lying flat. At around 19:00 hours Mrs Clark was noted to be unwell with reduced oxygen saturation and reduced conscious levels. Pulmonary embolism, chest infection (possible aspiration) and or opiate toxicity were considered as potential causes. She received treatment with oxygen IV fluids and antibiotics. Naloxone was also given to reverse the effect of the opiate medication. A pulmonary embolism was ruled out. Mrs Clark continued to receive treatment in the form of fluids, antibiotics and oxygen. Sadly however she passed away at Queens Hospital on the 11th November 2018. It is likely that the fall and long lie/immobility caused by the fractured femur and the administration of 30 milligrams of morphine over a 2 hour 20 minute period, contributed to her death.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – The doctor who prescribed the morphine at Queens Hospital had not appreciated that the London Ambulance Service paramedics had administered 20 milligrams of morphine. If he had been aware of this he would not have administered a further 10 milligrams. The doctor did not note that the paramedics had referred to **mls** as opposed

	to **mgs** in the medication section of the Patient Report Form. The doctor confirmed that the units used in hospital are mgs. It was agreed by all witnesses that great care needs to be taken in the administration of opiate medication. It was agreed that the use of different units by the pre-hospital service and the hospitals themselves creates risk and creates concern as to the risk of future deaths. It is requested that the Trust liaise with the London Ambulance Service to determine whether the units for administration of opiate medication can be standardised between the hospitals and pre-hospital services.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **12th February 2020**. 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 [redacted] (daughter of the deceased), the London Ambulance Service, Care Quality Commission and Director of Public Health. 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.
9	**19/12/2019**