REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Secretary of State for Health**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 5th June 2014 I commenced an investigation into the death of **Brian Marks** dob 10th June 1950. The investigation concluded on the 26th January 2015 and the conclusion was one of **Natural Causes**. The medical cause of death was 1a Aspiration Pneumonia 1b Dysfunctioning Percutaneous Endoscopic Jejunostomy 1c Motor Neuron Disease and 11 Chronic Type Two Respiratory Failure
4	**CIRCUMSTANCES OF THE DEATH** **For some considerable time he had been suffering from motor Neuron Disease. As a result he was fed and given medications via a P.E.J. tube. Whilst in hospital in the last stages of life having already aspirated and contracted pneumonia, it was felt that his tube had malfunctioned. A nurse tried to replace the tube, thinking that it was a P.E.G. tube rather than a P.E.J. tube. I was told in evidence that the tubes, when in situ, are very similar in appearance and yet the procedures for one are very different from the procedures for the other. As a result of the interference with the tube, the patient could not be fed nor given medication or fluids via that route and had to have these intravenously.**
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. – **The appearance of the PEJ tube and the PEG tube are very similar and could be easily confused the one with the other. In discussion with the witnesses, including the lead dietician, it was agreed that a simple colour coding system could be implemented so that even when in situ, the tubes would be immediately able to be differentiated.**
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 by **26th March 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 namely [redacted] (wife of the deceased). I have also sent a copy to [redacted] **Head of Risk, Stockport NHS Foundation 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. 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	**29.1.2015** [redacted] **John Pollard, HM Senior Coroner**