	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Simon Stevens, Chief Executive, NHS England P O Box 16738 Redditch B97 9PT** **2. National Patient Safety Alerting System, NHS England**
1	**CORONER** I am Jacqueline Devonish, assistant coroner, for the coroner area of Inner North 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.
3	**INVESTIGATION and INQUEST** On 14 December 2015 commenced an investigation into the death of Patricia Steer aged 81 years. The investigation concluded at the end of the inquest on 10 May 2016. The conclusion of the inquest was that she died after the clamp was briefly left open on a central venous catheter port resulting in air embolization and cerebral infarction.
4	**CIRCUMSTANCES OF THE DEATH** On 1 June 2015 Mrs Steer was admitted to the Homerton Hospital for an elective right sided total knee replacement. She made a good recovery and was discharged on 8 June. On 11 June she returned to hospital unwell with sepsis, which was treated effectively using a central venous catheter. On 16 June 2015 she became unresponsive when a staff nurse left a port on the CVC (octopus) open to air as she turned away briefly during the process of flushing and changing this to a single needle connection. Mrs Steer was, up until that point, clinically well and lucid, and had been placed to sit in a chair after the morning ward round. The staff nurse attended and found her sitting in a chair when she commenced the procedure. The staff nurse knew that she should clamp the line but did not know the reasons for this. Neither did she know that undertaking this change whilst Mrs Steer was sitting up would present a risk of air emobilization.
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. – (1) Neither the staff nurse who changed the catheter nor the supervising senior staff nurse who was present throughout the procedure were aware of the risk of air emobilization in the process of changing the catheter, where as it was in this case, left uncapped and unclamped. Whilst the attending Consultant was aware of the risk, the Serious Incident Investigator identified that it had not been possible to locate any literature or guidance on this point, having contacted other Trusts, and making an extensive literature search. The relevant bibliography was made available to the inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or 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 26 July 2016. 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: [redacted]. 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	**25 May 2016** Jacqueline Devonish