REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Dr Jackie Bene, CEO Bolton NHS Foundation Trust, Minerva Road, Farnworth, Bolton BL4 0JR
1	**CORONER** I am John Pollard Assistant Coroner, for the Coroner Area of Manchester West
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 the 23rd June 2016 I commenced an investigation into the death of Colin Garth, born on the 1st May 1963. The investigation concluded at the end of the Inquest on the 20th October 2016. The Medical Cause of Death was: 1a Sepsis 1b Hickman Line Infection and Pneumonia 1c Disseminated Colonic carcinoma 2. Ischaemic Heart Disease The conclusion of the Inquest was Misadventure.
4	**CIRCUMSTANCES OF THE DEATH** On the 5th May 2016 the deceased was diagnosed with colon cancer. He was operated on, on the following day and on the 10th May a Hickman line was inserted. He was discharged from hospital knowing that he was terminally ill. He was readmitted on the 18th June and he died on the 19th June at the Royal Bolton Hospital.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows:

	A. During the course of the evidence I was told that when patients are discharged from the hospital with a Hickman or central line in situ, they are not furnished with any guidance booklet or sheet as to how the said line should be monitored, cleaned, flushed etc. It is clearly desirable that they should be as well informed as possible and I therefore consider that the provision of such written advice should be considered. B. Whilst I was satisfied that the Trust does have a clear Policy as to the provision of and use of such lines, there was clearly a lack of knowledge of this policy even amongst quite senior staff members. There should be consideration given to a proper continuous programme of information and education for ALL staff. C. In evidence I was told that at one point the syringe driver (or the extension from it) became blocked and ceased to deliver the fluid as intended by the doctors. This is a fault which can happen in the best of all worlds. What concerned me greatly, however, was that the machine did not sound any bleep or alarm to indicate that it was faulty and having cleared the blockage, the nurse then reconnected the same machine rather than referring it for repair/replacement. There was a very clear need for education of the staff as to how important it is to ensure that all machines are operating properly and safely.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/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 the 15th December 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: (1) [redacted] Mr Garth's wife on behalf of the 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.	
9	**Dated** **20th October 2016**	**Signed** **John S Pollard**