	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Robin Woolfson, Medical Director, Royal Free Hospital** **2. Divisional Quality and Safety Board, Royal Free Hospital**
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 2 August 2018 I commenced an investigation into the death of Patrick Stephen Moran, aged 70. The investigation concluded at the end of the inquest on 5 January 2018. The conclusion of the inquest was death by natural causes from multi organ failure due to Iliac artery rupture (operated), due to sever peripheral vascular disease, with underlying osteoporosis and pulmonary hypertension
4	**CIRCUMSTANCES OF THE DEATH** Mr Moran was admitted acutely to the Royal Free on 25 July having been seen at the vascular clinic at UCLH on 20 July 2017 due to ongoing leg pain with left foot gangrene on the tips of his toes and chronic peripheral vascular disease. He was expedited urgently to theatre where an angiography and angioplasty of the left iliac system was performed under local anaesthetic. During the procedure he suffered an iliac artery rupture, which was successfully treated. He initially made good clinical progress. However, the left lower limb became non-viable and an above knee amputation performed. His right lower limb then deteriorated and it was agreed that the collective morbidity meant that further interventions would be futile.
5	**<u>CORONER'S CONCERNS</u>** 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) During the procedure under local anaesthetic on 25 July 2017 Mr Moran continued to bleed due to the unknown existence of the rupture at that time. He developed hyperkalaemia and was administered an insulin-dextrose infusion. He was to be infused 10 units (0.1ml) on insulin but was mistakenly infused with 100 units (1ml). The serious incident investigation identified that the ST4 Anaesthetist did not use an insulin syringe but instead used a normal 1ml syringe. The use of this syringe was common practice within the anaesthetic department in spite of the issue of alert NPSA/2010/RRR013. (2) Since 2010 diabetes was removed from the mandatory training requirements across the organisation. As a result there is currently no mandatory training provided to doctors within the Trust to advise them of use of insulin specific devices when drawing up and administering insulin. It is apparent from the action plan that emails have been sent to Consultant Anaesthetists in this regard.

	(3) There is currently no process across the organisation to review continued compliance with CAS alerts and ensure that changes made across the Trust still reflect the requirements of previously issued alerts.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 9 March 2018. 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 Person, [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	**5 January 2018** Jacqueline Devonish