Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Department of Health and Social Care** [redacted]
1	**CORONER** I am Mrs D HOCKING, His Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire
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 15 September 2022 I commenced an investigation into the death of Richard Nigel KEW aged 70. The investigation concluded at the end of the inquest on . The conclusion of the inquest was that: **Mr Kew was admitted to the Glenfield Hospital Leicester and underwent a resection of small bowel endocrine tumour with extensive lymphadenectomy and resection of multiple liver metastases on the 21 July 2022. Immediately post-operatively he was admitted to the adult Intensive Care Unit. During mobilisation of Mr Kew on the 22 July there was an inadvertent omission to secure one of the central venous catheter lines with a bung. This omission allowed air entrainment into Mr Kew's circulation. His condition deteriorated rapidly and whilst he received immediate senior medical attention, he never regained consciousness and died as a direct result of the consequences of the omission on the 05 September 2022.**
4	**CIRCUMSTANCES OF THE DEATH** As above with a cause of death as 1a) **Diffuse Hypoxic Brain Injury** **1b) Air entrainment via a central venous catheter** **1c) Peri-operative requirement for physiological support** **1d) Ileocolic anastomosis and resection of liver metastases to treat small bowel neuroendocrine tumour and multiple liver metastases**

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: That whilst the University Hospitals of Leicester(UHL) have taken adequate and acceptable steps following this incident to prevent this occurrence ever happening again. In particular the UHL have now adopted a policy of having bionectors at the end of patent lines instead of relying upon a simple bung and particular training for nurses in the correct and safe way to ensure safety of the lines whilst moving patients ensuring that this aspect has become a specific competency in training. However, I am concerned that other Trusts may not have such policies and procedure in place to prevent the inadvertent error of not capping a patent line of a central venous catheter during the mobilisation of a patient.
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 April 04, 2023. 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] **(wife)** **University Hospitals of Leicester** I have also sent it to the **Heath and Safety Investigation Board (HSIB)** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 07/02/2023**  **Mrs D HOCKING** **His Majesty's Assistant Coroner for Leicester City and South Leicestershire**