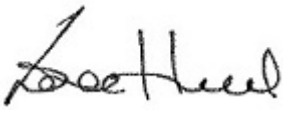
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. University Hospitals Birmingham NHS Foundation Trust
1	**CORONER** I am Louise Hunt, HM Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 8 January 2024 I commenced an investigation into the death of Peter Jason FANNING. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Natural causes
4	**CIRCUMSTANCES OF THE DEATH** Peter was born with cerebral palsy which caused severe physical impairment. He communicated using a liberator device and received a full package of care at home. He was fed using a gastrostomy tube with a jejunal extension which became dislodged periodically and he suffered from epilepsy and episodes of aspiration pneumonia. In 2022 and 2023 there were repeated dislodgments of his feeding tube resulting in him being admitted to hospital for replacements which impacted on his nutritional state and frailty. He was admitted to the Birmingham Heartlands Hospital on 07/11/23 after a further dislodgement of his feeding tube which was replaced on 15/11/23 due to there only being one radiology list per week for complex feeding tube replacements. He was discharged home on 18/11/23. The feeding tube dislodged again requiring further admission on 24/11/23. The tube was reinserted on 28/11/23 but unfortunately became dislodged again on 30/11/23. Peter was treated for severe pneumonia on 30/11/23. A PICC's line was inserted on 05/12/23 to provide total parenteral nutrition until a further more permanent feeding tube could be inserted surgically on 13/12/23 but this PICCS line also dislodged on 07/12/23 and had to be replaced on 11/12/23. Peter deteriorated with further symptoms of pneumonia on 15/12/23 and sadly died on 19/12/23. Following information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Pneumonia** **1b Frailty** **1c** **II Epilepsy, Cerebral Palsy**
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. The inquest heard evidence that there is only one radiology list per week to accommodate replacement of feeding tubes in patients with complex needs. In Peter's case this meant he had to wait a week for the tube to be replaced meaning he had suboptimal nutrition during this period. Consideration should be given to whether additional services are required for replacement of feeding tubes in patients with complex needs. 2. The inquest heard evidence that Peter's nutritional status was suboptimal due to repeated tube dislodgments and waiting for radiology or theatre slots to be available. Consideration needs to be given as to how best to maintain patients' nutrition after tube dislodgments when they rely on feeding tubes.
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 2 July 2024. 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 have also sent it to the Medical Examiner, ICS, NHS England, CQC, 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	**7 May 2024** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**