REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Mid & South Essex NHS Trust**
1	**CORONER** I am Sonia Hayes, area coroner, for the coroner area of Essex
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. [HYPERLINKS]
3	**INVESTIGATION** On 7 March 2024 I commenced an investigation into the death of THOMAS ADRIAN BURROUGHS, AGE 35. The inquest has not yet concluded, the inquest is adjourned part-heard.
4	**CIRCUMSTANCES OF THE DEATH** Thomas Burroughs was a 35-year-old learning disabled man who was nonverbal with a medical history of Cerebral Palsy, Scoliosis and Pressure Ulcers and was nil by mouth with PEG feeding in situ. Mr Burroughs had prolonged admission in hospital from 6 September to 23 November 2023 and readmitted on 29 November 2023 and was treated for recurrent aspiration pneumonia. During his hospital admissions Mr Burroughs feeding regime was on hold for periods of time during his admission. Mr Burroughs underwent procedures that included insertion of a Hickman Catheter and later a jejunal extension. Mr Burroughs died in hospital on 22 February 2024.
5	**CORONER'S CONCERNS** During the course of the part-heard inquest, the evidence 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. – (1) On 13 January 2024 acute Trust Hospital ward staff noted a split in the lumen of the Hickman Catheter and this was clamped and dressed. (2) The incident was escalated for urgent medical review due to the significant risk of infection, however no Datix was raised for the split Hickman Catheter as required by the acute Trust protocol.

	(3) Mr Burroughs had a jejunal extension to his PEG on 15 January 2024. Advice was received that the Hickman Catheter should be removed as soon as possible if it was not being used. (4) Mr Burroughs was tachycardic and spiked a temperature on 19 January 2024 with no apparent symptoms of recurrent aspiration and the Hickman Line remained in situ. (5) The Hickman Catheter was surgically removed on 30 January 2024.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 **10 February 2025**. 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 Family Cambridgeshire University NHS Hospitals Trust Hamelin Trust LeDeR (Learning from Lives and Deaths- People with Learning Disability and Autistic People) 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. She 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	S. M. Hayes **HM Area Coroner Essex** **12 December 2024**