MR G IRVINE
SENIOR CORONER
EAST LONDON CORONERS COURT
124 Queens Road Walthamstow, E17 8QP
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive Officer, Barts Health NHS Foundation Trust** **Sent via email:** [redacted] **2. [redacted], Secretary of State for Dept. Health & Social Care** **Sent via email:** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 27th December 2024, this court commenced an investigation into the death of Kenneth Foster, aged 79 years. The investigation concluded at the end of the inquest on 9th May 2025. The court returned a narrative conclusion. *"Kenneth Martin Robert Foster died in hospital on 25th November 2024 due to pneumonia caused by the aspiration of stomach content during a seizure. Mr Foster suffered from epilepsy caused by a traumatic brain injury sustained in 2012. Mr Foster was admitted to hospital on 3rd September 2024 due to seizures. Mr Fosters seizure*

	activity was managed through a number of anti-convulsant medications, seizure activity was not observed for 5 weeks. On 11th November 2024 Mr Foster removed a naso-gastric tube used for feeding and the administration of clobazam an anti-convulsant. The removal of the tube led to an interruption in the administration of clobazam for 13 hours. The same day Mr Foster suffered a resumption of seizure activity, he was later diagnosed with aspiration pneumonia which ultimately led to his death." Mr Foster's medical cause of death was determined as; 1a Aspiration pneumonia 1b Status Epilepticus 1c Complex partial seizures 1d Traumatic brain injury 2012 L fronto-parietal subdural subarachnoid haemorrhage and temporal bone fracture
	CIRCUMSTANCES OF THE DEATH Kenneth Foster sustained a head injury in 2012 which caused a stroke. Mr Foster suffered from epilepsy thereafter. On 3rd September 2024 Mr Foster sustained prolonged seizure activity, he was taken to hospital by ambulance. Mr Foster was admitted to hospital and initially, was treated on the ITU. On 14th September he had recovered sufficiently to be stepped down to ward-based care and through a series of medications sustained a five-week period without a seizure. On 1st November 2024 Mr Foster removed a naso-gastric tube used for feeding and the administration of clobazam - an anti-convulsant. The reinsertion of the naso-gastric tube was delayed for eleven hours. During this period no thought was given to administering clobazam in a different manner. A total interruption in the administration of clobazam lasted for for 13 hours. The same day Mr Foster suffered a resumption of seizure activity, he was later diagnosed with aspiration pneumonia which ultimately led to his death.
5	**CORONER'S CONCERNS** During the course of the 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. – A. A failure in governance at the Trust meant that this case was not identified as an incident worthy of investigation through the Patient Safety Framework. This omission gives rise to a concern that future deaths may follow due to an inability on the part of the trust to identify, reflect upon, and remediate sub-optimal practice. In this case the trust's Datix incident reporting system, morbidity and mortality meeting process and PSIRF procedure were inadequate.
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 **16th July 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 the family of Mr Foster, the Care Quality Commission and to the local Director of Public Health 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 other 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.
9	**[DATE] 12/05/2025 [SIGNED BY CORONER]**