GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

[redacted]

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive National Institute for Health & Care Excellence (NICE)**
1	**CORONER** I am **Rachel Knight H M Coroner**, for the coroner area of South Wales Central.
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 3 February 2022 I commenced an investigation into the death of Peter Malcolm THOMAS . The investigation concluded at the end of the inquest 02/09/2025 . The conclusion of the inquest was the following narrative:

	Peter Malcolm Thomas was aged 78 and had developed peripheral vascular disease which led to necrotic and subsequently gangrenous toes. This became osteomyelitis of the foot, and a wider spread, more significant infection. On 15th January 2022, Peter collapsed and was taken into the Royal Glamorgan Hospital, Llantrisant, where he was treated with antibiotics and fluids. Sadly, his condition deteriorated significantly, and his infection became a systemic sepsis until he became unconscious and sadly died on 19th January. Although Peter was given diazepam as a sedative, a treatment he did not require, on balance it did not contribute more than minimally to the development of bronchopneumonia, from which he ultimately died. His cause of death was found to be: **1a Bilateral Bronchopneumonia** **1b Osteomyelitis of the Foot** **1c Peripheral Vascular Disease** **II**
4	**CIRCUMSTANCES OF THE DEATH** It was identified early upon admission that Peter was likely suffering from a serious infection as well as delirium. A clinician undertaking an examination took an account from Peter which led him to instruct the CIWA protocol to be used, due to information provided by Peter and some concerning signs and symptoms. In fact, CIWA was a red herring, as Peter was not in alcohol withdrawal, he was confused and delirious and gave an erroneous account of having been drinking. The signs and symptoms he exhibited were more likely due to the serious infection taking hold of him and leading to shaking, sweating, agitation and anxiety. His false account was likely due to confusion or delirium. No collateral information was sought from medical records, nor from capacitous family (who would have been available by phone very easily) and when Peter's symptoms scored against the CIWA protocol, he was given 80mg of diazepam over 6 hours. He did not require this drug and at 78 with serious comorbidities and a developing sepsis, his metabolism of it was likely hindered. 2 doses of the antidote were subsequently given but Peter did not regain consciousness. He went on to die from pneumonia. The Inquest focused upon:- a. The use of CIWA with Peter at all b. The dosing suggested within CIWA c. The effect of the diazepam and its contribution to Peter's death
5	**CORONER'S CONCERNS**

[redacted]

	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) I am concerned that the CIWA protocol is something of a blunt instrument, not at all nuanced to take account of for example, advancing age and different metabolic rate, delirium and confusion and lack of collateral evidence (2) Clinicians without further guidance on its use, will continue to be at risk of implementing the CIWA protocol and prescribing sedatives at significant dose and frequency when it is not required, which presents risks of over-sedation and its consequences, particularly in the elderly and potentially delirious cohort, based upon pattern recognition rather than reliable evidence (3) the NICE guidelines on the management of alcohol withdrawal do not explicitly deal with the situation here, which could well recur and lead to future deaths
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 29th October 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 family who may find it useful or of interest. Also, a copy will be sent to the Chief Executive of Cwm Taf Morgannwg Health Board and Cardiff & the Vale Health Board for their information and consideration.

[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. She may send a copy of this report to any person who she 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	3 September 2025 **SIGNED:** [redacted] Rachel Knight H M Coroner for South Wales Central Coroner Area