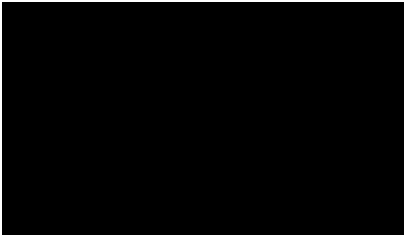


	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: CHIEF EXECUTIVE OF UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
1	CORONER I am Adam Hodson, Area Coroner for Birmingham and Solihull
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INVESTIGATION and INQUEST On 10 April 2025 I commenced an investigation into the death of John Christopher RUST. The investigation concluded at the end of the inquest. The conclusion of the inquest was that John died due to an uncontrolled CSF leak following elective thoracic aortic replacement surgery
4	CIRCUMSTANCES OF THE DEATH On 25/03/25, John was admitted to the Queen Elizabeth Hospital for a elective thoracic aortic replacement, having been diagnosed with a Type B aortic dissection in October 2019. On 26/03/25 he had a cerebrospinal fluid ('CSF') catheter inserted to minimise post-operative risks of paraplegia that is common with the type of surgery. On 27/03/25, the surgery went ahead without major complications, and he was transferred to ITU to recover. On 28/03/25, there was over-drainage of the CSF drain, and there were concerns raised about a possible CSF leak, which were not acted upon. John's neurological status started to deteriorate which was put down to side effects of medication. At 20.32 hours, Johns' CSF drain was noted to have become disconnected which had resulted in him having a period of unmonitored and uncontrolled CSF loss, and sadly which caused him to suffer a catastrophic and unsurvivable brain injury. He was kept comfortable, and he passed away at 18:36 on 29/3/25, following which John made the generous gift of organ donation. The evidence is that that John's death was avoidable had concerns surrounding the CSF leak been acted upon sooner. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a Intracerebral haemorrhage 1b Excess CSF drainage 1c Lumbar drain, replacement of thoracic-abdominal aortic aneurysm 1d II Chronic Type B Dissection, Hypertension.
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. In accordance with the PSII report (#SE-48448), a specific recommendation was made that <i>"All clinical staff (medical and nursing) using automated CSF drainage systems such as Liquoguard must have completed adequate training to ensure that they are familiar with the functionality of the device prior to use..."</i> 2. The evidence at inquest was that this training was not mandatory at present, and that at the time of the inquest, approximately 55% of the relevant staff have received the training. This has been slowed down somewhat due to a representative of the company being off sick, but further training sessions have been planned. 3. However, the evidence of [REDACTED] (author of the PSII report and consultant neurosurgeon) indicated that it was his view that the training should be mandatory, and that consideration must be given to ensuring this is rolled out in a "sustainable" way to staff - both current and future - as opposed to a "knee-jerk reaction" where training is only given to a limited number of staff following an incident. 4. There was no evidence before the court that there was any plan to embed this training and ensure that it is carried out in a "sustainable" way, with a particular focus on ensuring that future staff are adequately and properly trained. This was particularly concerning given the apparent high rotation and through-put of staff in the ITU department. It became apparent to me that the training being offered was the type of "knee-jerk reaction" that [REDACTED] was fearful of. 5. There is a risk of future deaths occurring where clinical staff (medical and nursing) do not receive adequate training on equipment. 6. As Coroner, it is not my role to advise what action needs to be taken - that is a matter for your organisation.
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 15 December 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 Mr Rust's next of kin I have also sent it to the Medical Examiner 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. 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	20 October 2025  Signature: Adam Hodson Area Coroner for Birmingham and Solihull
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