Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Association of Anaesthetists** **2 Royal College of Anaesthetists** **3 Royal College of Surgeons**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
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 29 January 2025 I commenced an investigation into the death of William KING aged 32. The investigation concluded at the end of the inquest on 10 September 2025. The conclusion of the inquest was a narrative one. William King, known as Billy King, died on the 26th January 2021 at Milton Keynes University Hospital as a result of an aspiration episode during preparation for emergency laparotomy for bowel obstruction. The cause of death was multi-organ failure due to pulmonary aspiration with sepsis, following laparotomy for small bowel obstruction under general anaesthetic. Billy was admitted with a small bowel obstruction and declined a nasogastric (NG) tube on several occasions. The inquest found that the necessity and risk of declining the NG tube were not sufficiently explained or documented at any stage. Had an NG tube been placed, it is probable in my view that Billy would have survived.
4	**CIRCUMSTANCES OF THE DEATH** Billy King was admitted to Milton Keynes University Hospital (MKUH) on the 22nd January 2025 with a mechanical small bowel obstruction proven on CT scan of his abdomen. He had previously had both an appendicectomy and then subsequent laparotomy with division of adhesions resulting from the first surgery. He had had a nasogastric tube placed for the first laparotomy and found it unacceptable. He was assessed as being suitable for initial conservative management which I found was acceptable practice. As part of that he was offered but declined a nasogastric tube. There are no notes documenting the first time this was discussed and I was unconvinced by oral evidence that the necessity and risk had been sufficiently explained to him. He initially improved then deteriorated and a decision was made for laparotomy on a daytime list. The night before he had vomited and there is a record of a further discussion of placement of a nasogastric tube. The record is poor and again does not document that the necessity and risk had been properly explained. He was allowed to have food in the form of a yoghurt or jelly and the family report him sending photo's of that. The provision of food was documented in the notes. He was seen by the duty Consultant Emergency Surgeon on the 25th January 2025 prior to surgery. He told me he had offered a nasogastric tube but again did not record what was said and agreed he had not stressed the risk. Billy was taken to the anaesthetic room where he underwent modified rapid sequence induction of anaesthetic. It was admitted that the dose of the

	paralysing agent, rocuronium, was lower than it should have been. I found that did not make a material difference to the outcome. During the apnoeic phase of the induction of anaesthesia an oropharyngeal airway was placed, within the 1 minute interval rocuronium apparently takes to paralyse. This caused Billy to vomit. Suction was applied. A CT1 trainee was managing the airway under the direct supervision of a Consultant Anaesthetist. A Cormack grade 1 view (full view of the glottis) was achieved. Gastric contents were visible during the laryngoscopy. This was managed by suctioning the contents. The amount suctioned at induction was 1.2 Litres. The intubation was taken over by the Consultant and achieved. A nasogastric tube was passed. Total volume of fluid suctioned and aspirated via NG tube was in the order of 4.7 litres. During the procedure it became evident that Billy had had a significant aspiration. He was moved promptly following a surgically successful procedure to the ITU where he died. I am of the view that had an NG tube been placed it is probable that Billy would have survived this episode.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) i) Failure to document consent discussions - The record of discussions with Billy about the NG tube was poor. Despite the Trust having a "Policy & Guidelines for Consent to Examination or Treatment" in place since January 2020 (reviewed February 2024), there was a failure to comply with these guidelines in Billy's case. The policy required clear documentation, but this was not followed in Billy's case. The Trust's subsequent assertion in submissions that policy and training are sufficient is undermined by the fact that the policy was in place but not followed ii) Inadequate explanation of risks to patients - I found that the necessity and risks of declining the NG tube were probably not sufficiently explained to Billy at any stage. There was certainly no supporting evidence to suggest the contrary. iii) Policy non-compliance - Despite a comprehensive policy being in place, there was a failure to implement it in practice, suggesting a gap between policy and practice that may affect other patients. The existence of a policy is not sufficient if it is not followed in practice. The inquest demonstrated a failure of implementation, not of policy content. iv) Absence of clear responsibility - There appeared to be a disconnect in terms of who was actually responsible for ensuring the need for an NG tube was explained to Billy. The assessing anaesthetists thought he needed an NG tube and the surgeons thought he needed an NG tube, but neither took ultimate responsibility for ensuring that this was adequately and, if needed, strongly explained and implemented. No one professional led on this vital aspect of his care. I conclude that, since the policy was not followed despite being in place, there remains a risk of recurrence unless there is assurance of effective implementation and monitoring. These concerns are likely to manifest and be replicated across England and Wales requiring me to send this report to the Royal Colleges and Association of Anaesthetists.
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 December 03, 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 **Milton Keynes University Hospital** [redacted] 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 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 by the Chief Coroner.
9	**Dated: 08/10/2025** [redacted] **Sean CUMMINGS** **Assistant Coroner for** **Milton Keynes**