IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Kenneth John WILLIAMS
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: The Chief Executive, Epsom and St Helier University Hospitals NHS Trust, Daniel Elkeles.
1	**CORONER** Simon Wickens HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into **Kenneth John Williams's** death was opened on the 28th June 2013 was resumed on the 17th March 2015. Conclusion was returned on the 30th March 2015. The cause of death was: 1a – right haemothorax 1b – rupture of pulmonary bulla (by insertion of chest drain) Box 3 was recorded as: Kenneth John Williams was admitted to Epsom General Hospital with shortness of breath on the 23rd June 2013. A diagnosis of tension pneumothorax was made and a chest drain was inserted. This was removed on the 24th June 2013 and after a deterioration in his health and the reinsertion of a chest drain he died on the 25th June 2013 at 10.30am. A subsequent review did not find a tension pneumothorax but a known emphysematous bulla. And the conclusion was; Kenneth John Williams died of complications following the insertion of a chest drain.

4	**CIRCUMSTANCES OF THE DEATH** On the 23rd June 2013, Kenneth John Williams was seen at Epsom General A&E for shortness of breath. A diagnosis of tension pneumothorax was made and a chest drain was inserted. Previous radiology was available to show the presentation diagnosed as a pneumothorax was actually an historic bulla. The initial chest drain collapsed the bulla and ruptured a vessel leading to progressive bleeding. The respiratory team were not involved and subsequent management proceeded upon the assumption the initial diagnosis of tension pneumothorax was correct. The Chest drain was removed on the 24th June 2013 and subsequently replaced when Mr Williams health began to deteriorate. Mr Williams passed away on the 25th June 2015.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed a number matters that gave rise to a concern that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken. The **MATTERS OF CONCERN** are as follows. – 1. Action is required to ensure that previous radiology, patients medical history and medication is always considered before a chest drain insertion or any invasive procedure is undertaken. 2. Action is required to ensure respiratory consultants opinion is sought where possible before inserting a chest drain. 3. Action is required to ensure the respiratory team is made aware of all patients who have had a chest drain inserted. 4. Action is required to ensure patents previous medical history, historical imaging and medications are always reviewed anew by any subsequent medical team receiving the patient from A&E. 5. Action is required to ensure all medical staff are trained how to access historical imaging.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Chief Executive has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the Interested Persons in the Inquest and the Chief Coroner.
9	**Signed:** *Simon Wickens* **DATED this 30th day of March 2015.**