REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **Mr John Adler** **University Hospitals of Leicester NHS Trust** **Belgrave House** **Leicester General Hospital** **Gwendolen Road** **Leicester** **LE5 4PW**
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire South
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 6 October 2015 I commenced an investigation into the death of Alan Tear. I returned the following narrative conclusion: Alan Tear died on the 1st May 2015, in Leicester General Hospital from post-procedure complications following the insertion of a biliary drain. At the time he was not being observed on the ward in accordance with his needs and opportunities to recognise and intervene were lost. It cannot be said whether any earlier intervention would on the balance of probabilities have altered the outcome. Cause of death 1a Intraperitoneal haemorrhage 1b Biliary drain insertion for obstructive jaundice 1c Cholangiocarcinoma 2. Ischaemic heart disease, hypertension, diabetes mellitus
4	**CIRCUMSTANCES OF THE DEATH** Mr Tear was receiving palliative treatment for cholangiocarcinoma. He underwent a drain insertion on 30th April 2015 by the interventional radiology team and appeared to cope well with this. It was recognised pre-operatively that there was a high risk of procedural complications and a 10% risk of mortality. He had appropriate observations in recovery and was then returned to the ward with post-operative instructions for regular observations. Most of these observations were not carried out. One set of observations that should have raised concerns did not result in any action. Mr Tear died 11 hours post-operatively from a bleed caused by the drain that had become misplaced and caused a perforation of the peritoneum.

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 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. Post-operative instructions were not followed by the nursing staff. 2. Post-operative observations were not reported to medical staff as required when the EWS was rising. 3. It was not clear that the Intervention Radiology team knew or understood what observations the nursing staff would carry out and the communication between the teams needs to be reconsidered.
	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 Wednesday 9th December 2015. 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 [redacted] daughter of the deceased Care Quality Commission. 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. 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	**[DATE]** **[SIGNED BY CORONER]** **14th October 2015**