

IAN MICHAEL ARROW Senior Coroner for Plymouth, Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Secretary of State for Health Rt. Hon Jeremy Hunt MP. Department of Health, Richmond House, 79 Whitehall London Sw1A 2NS
1	CORONER
	I am IAN MICHAEL ARROW, Senior Coroner for Plymouth, Torbay and South Devon, I Derriford Park, Derriford Business Park, Plymouth PL6 5QZ
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On 17/09/2015 I commenced an investigation into the death of Peter Charles Tye aged 73 years. The investigation concluded at the end of the inquest on 15 February 2016. The conclusion of the inquest was NARRATIVE The deceased was admitted to Derriford Hospital, Plymouth on 2 September 2015 and despite treatment sadly died on 10 September 2015. The medical cause of death was 1 (a) Gram Negative Septicaemia with Pneumonia and Diffuse Alveolar Damage Cerebral Infarct following Cannulation of the Cartoid Artery
4	CIRCUMSTANCES OF THE DEATH Mr Tye was admitted to hospital on the 3rd September with pneumonia / respiratory failure and unexplained weight loss. On the 4th September, whilst on ITU there was a recognised complication when a central line was inserted into his carotid artery instead of his vein. After this he remained stable for 2 days but then deteriorated with gram negative sepsis. His condition did not improve and he sadly died.
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
	At an Inquest touching the death of Peter Charles Tye, I received evidence from that improvements at Derriford Hospital had been made following the events during which a central venous line was misplaced into an artery. A Root Cause Analysis has indicated various improvements which can be made. These improvements concern both the insertion and the removal of central venous lines. Adoption of those processes is likely to reduce the numbers of deaths from misplaced lines.
	Details have been shared with the Faculty of Intensive Care Medicine. In my view deaths might be reduced by the promulgation of this good practice.

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you, The Secretary of State for Health have the power to take such action by promulgating the now developed best practice.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 April 2016. 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 Chief Executive, Derriford Hospital, President of the Faculty of Intensivists and
	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	Dated 15 February 2016
	SignatureSenior Coroner for Plymouth, Torbay and South Devon