| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO:<br><br>1. County Durham and Darlington NHS Trust<br>2. Department of Health |
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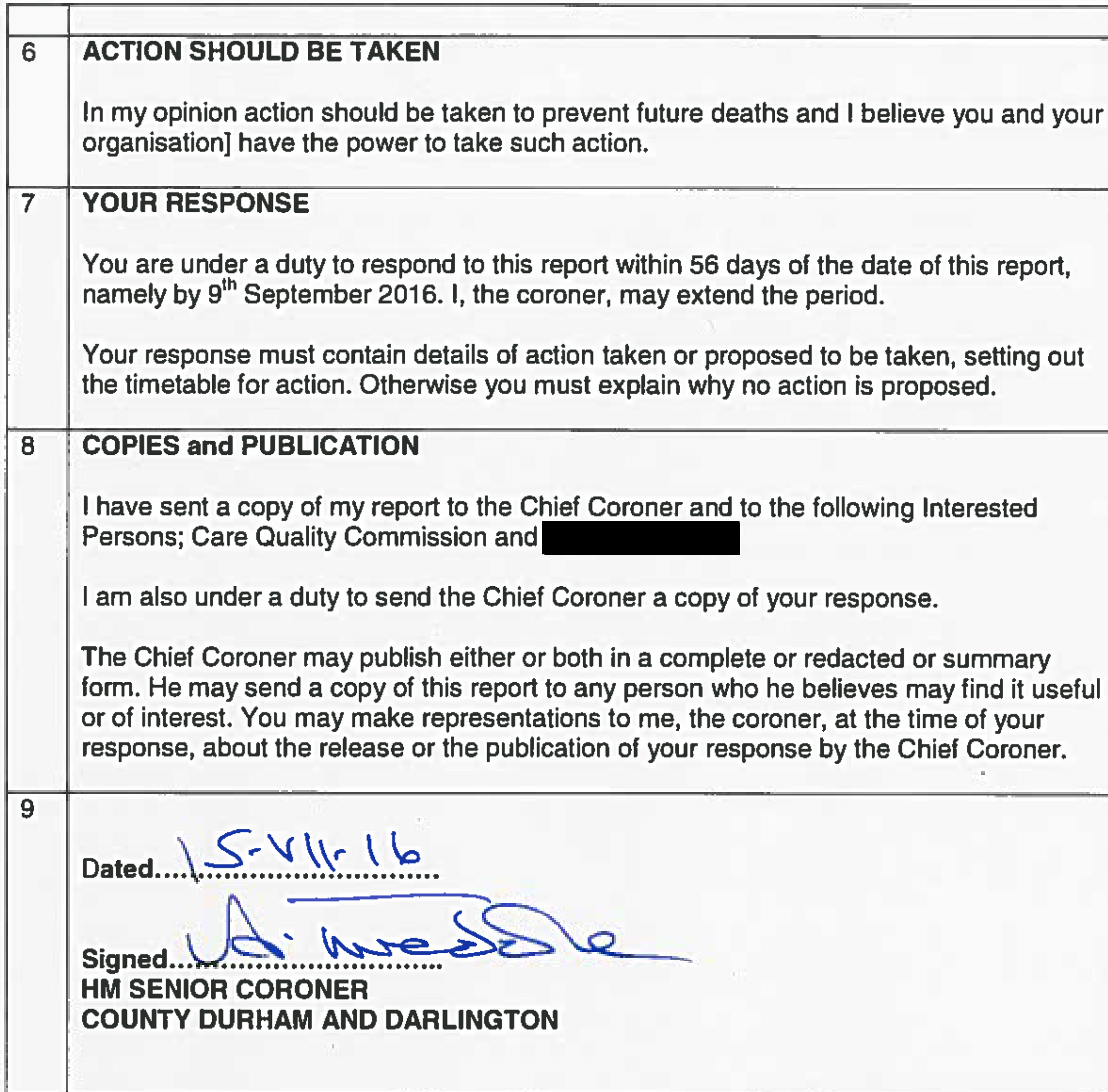
| 1 | **CORONER**<br><br>I am Andrew Tweddle Senior Coroner for the coroner area of County Durham and Darlington. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.<br>(see attached sheet) |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 12th January 2016 I commenced an investigation into the death of James Kane, 52 years. The investigation concluded at the end of the inquest on 14th July 2016. The conclusion of the inquest was Recognised Complication of Necessary Medical Intervention with a cause of death of 1a) Peritonitis, 1b) Bowel Injury following Paracentesis for Ascites, 1c) Alcoholic Liver Disease including Cirrhosis. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The deceased was admitted to hospital with gross ascites secondary to advanced liver cirrhosis. There had been some occasions where drains had been inserted following an ultrasound scan but some occasions where drains had been inserted without an ultrasound scan. On 2nd January 2016 a drain was inserted without a scan and some 7 and a half litres of fluid were drained prior to the drain being removed in the early hours of 3rd January. Within an hour of the drain being removed the deceased's condition had deteriorated markedly and he died later that day. It was accepted that the deceased had died of a well-known but rare medical complication. It is likely that at the time the drain was inserted an injury was sustained by the bowel. A consultant gave evidence to say that there was nothing in hospital guidelines to mandate an ultrasound scan prior to the insertion of a drain; that this was a very common procedure and that intuitively it would seem to be beneficial to have a scan prior to a drain being inserted. The matter had been referred to hospital authorities at a regional level and there was no support for a proposition that there should be a scan prior to the insertion of a drain. The family clearly took the view that their loved one would not have died at the time that he did but for the insertion of the drain and that, if a scan had been undertaken, this might have reduced the risk. They feel their loved one could have been that "1 in a million" and in their view therefore further consideration should be given to the risk. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>Notwithstanding that a local discussion of the circumstances of this case has taken place and there having been no local support for a change in policy or guidance, given the evidence that the deceased would not have died when he did but for the drain and that it is possible that a scan may have reduced the risk of death I believe this is a matter that requires further thought and consideration. |



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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you and your organisation] have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th September 2016. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; Care Quality Commission and [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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-VII-16...<br><br>**Signed**...[signature]...<br>**HM SENIOR CORONER**<br>**COUNTY DURHAM AND DARLINGTON** |