REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **RE: Amanda Coulthard Deceased** **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive of North Cumbria University Hospitals NHS Trust** **2. The Chief Executive of NHS England** **3. The Secretary of State for Health**
1	**CORONER** I am David Ll. Roberts, Senior Coroner, for the coroner area of Cumbria.
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 29th April 2015 I commenced an investigation into the death of Amanda Coulthard aged 57 years. The investigation concluded at the end of the inquest on 16th January 2017. The conclusion of the inquest was: 1. Medical Cause of Death: 1a) Aspiration Pneumonia; 1b) Insertion of a nasogastric tube and administration of feed and medication into the right lung in the treatment of multiple sclerosis. 2. How, when and where, and for investigations where section 5(2) of the Coroners and Justices Act 2009 applies, in what circumstances the deceased came by her death. Amanda Coulthard died at 07.10 on 26th April 2015 at the Cumberland Infirmary, Carlisle following the insertion of a nasogastric tube into her right lung resulting in Mrs Coulthard developing aspiration pneumonia from which she died. 3. The deceased died from aspiration pneumonia. The pneumonia developed because a Nasogastric Tube was placed in such a way as to enter the right lung instead of the stomach. The tube was inserted at 14.20 on 17th April 2015. An unsuccessful attempt to draw aspirate was made and an x-ray to confirm the nasogastric tube's position was authorised. At 17.00 a further attempt to obtain aspirate was made in the absence of a second checker in breach of Trust Policy, training and national best practice. The pH of the aspirate was incorrectly read from a pH strip. These failings amount to neglect. This resulted in the misplacement of the tube being undetected. Feeding was commenced. 525 ml of liquid was administered via the tube and entered the deceased's right lung resulting in the development of the pneumonia from which she died.
4	**CIRCUMSTANCES OF THE DEATH** Amanda Coulthard suffered from multiple sclerosis. In April 2015 she was transferred from Penrith Hospital to the Cumberland Infirmary, Carlisle due to poor health and for further investigation. Her prognosis was not good. As part of her treatment plan it was decided that a nasogastric tube (NGT) be inserted to deliver nutrients and medicine. An

	NGT was fitted on 14th April and its position checked by x-ray. She pulled tubes out on 14th and 17th April 2015. On 17th April 2015 a fresh NGT was inserted. As no aspirate was obtained the plan was for an x-ray. Records note that aspirate was obtained and feed commenced. The x-ray was abandoned. She subsequently began coughing up blood. Shortly after midnight on 18th April 2015 an x-ray showed the NGT in the right lung. She was, in view of her condition, treated conservatively. She died on 26th April 2015.
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. – I have now held inquests into 3 deaths as a result of misplaced nasogastric tubes at North Cumbria Hospitals which occurred over a period of a little over 7 years. These types of death are described as 'Never Events'. On the facts of these three cases the deaths were avoidable. Common themes in all were: (a) Staff not being aware of the policy. (b) Staff not reading the policy. (c) Staff not applying the policy. (d) Staff not following good practice. (e) The Trust not ensuring compliance nor rolling out training to all who needed it. (f) Lack of checks and audits to establish competence and adherence to policy. (g) Failure of the Trust to learn from the first death. (h) Lack of Corporate Memory (the issue of NGTs was not on the Risk Register). (i) The Trust not fully implementing the 2011 NPSA Alert for over two years and only as a result of the second death. (j) Even after the second death not having systems in place to ensure compliance on the ward which contributed to the third death. (k) The Trust Policy growing in size from 20 to 36 pages in 7 years, making it difficult for busy practitioners to absorb (there are some 200 Policies in the Trust). (l) The current Policy has cross-references to paragraphs which do not exist. These errors have been carried through three versions, and raise the risk of misinterpretation by staff and undermining their confidence in such an important document.
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. In my view the following action should be taken: (a) **The Trust** should take steps, (i) To consider an amplified "summary and aim" at the beginning of the policy to drive home the main points. (ii) To identify areas where statutory or mandatory training is required. (iii) To consider the implementation of an online system of statutory mandatory training with a central recording system. (iv) To take steps to ensure that good and compliant practice is actually taking place on the wards. (v) To correct cross referencing errors in the Policy. (b) The **Secretary of State** and **NHS England** should take steps to ensure that, (i) Research is undertaken to identify a superior method of ensuring correct nasogastric tube placement. (ii) The issues identified above are addressed nationally –there is evidence set out in the NHS Improvement Resource Set 'Initial Placement of

	NGTs' July 2016 that demonstrates that the themes set out above are being replicated across other Trusts. (iii) The 2011 Alert is properly implemented nationally – the evidence before me was that it has not been.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th March 2017. 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: a) [redacted] and Solicitors b) [redacted] and Solicitors c) [redacted] and RCN d) [redacted] and Solicitors e) [redacted] and Solicitors f) [redacted] g) [redacted] h) [redacted] i) [redacted] j) [redacted] k) [redacted] l) [redacted] I have also sent it to persons named below who may find it useful or of interest. a) [redacted] b) c) d) GMC e) NMC f) Cumbria CCG g) [redacted] h) i) 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	**18th January 2017** ..... **D. Ll Roberts** **HM Senior Coroner**