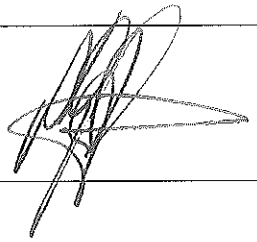
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 3 FEBRUARY 2017 IS BEING SENT TO:** **Mr Adam Cairns, Chief Executive, Cardiff and Vale University Health Board**
1	**CORONER** I am Philip Charles SPINNEY, Area Coroner, for the coroner area of South Wales Central.
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 5 October 2016 I commenced an investigation into the death of David Robert Griffiths. The investigation concluded at the end of the inquest on the 31 January 2017. The conclusion of the inquest was a narrative conclusion as follows: *David Robert Griffiths developed a pleural effusion after a coronary artery bypass grafting procedure. During the procedure to drain the pleural effusion the pleural drain penetrated his heart causing it to stop.*
4	**CIRCUMSTANCES OF THE DEATH** On 29 September 2016 at the University Hospital of Wales David Robert Griffiths underwent a procedure to drain a pleural effusion. The procedure was undertaken without the use of real time ultrasound guidance as this was not available. In addition, the drain was not inserted at the location identified and marked by an earlier ultrasound, although it was inserted in the recognised "triangle of safety". During the procedure the pleural drain penetrated Mr Griffiths' heart (which is a rare but recognised complication of the procedure). Despite treatment 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. – (1) The evidence revealed that there were no local cardiothoracic department protocols that were available to guide the insertion of intercostal drains and no specific training given to new medical and nursing staff. (2) The British Thoracic Society Guidelines strongly support the use of real time ultrasound guidance when inserting chest drains for fluid. Real time ultrasound

	guidance was not available in this case.
6	**ACTION SHOULD BE TAKEN** **(1) Consideration should be given to reviewing your procedures related to chest drain insertion and consider introducing an induction programme for all new medical and nursing staff.** **(2) Consideration should be given to the acquisition of appropriate ultrasound equipment to allow real time guidance of chest drain insertion, pleural procedures and diagnostics.** **(3) Consideration should be given to an ultrasound training programme and governance structure for all practitioners who are responsible for the insertion on intercostal drains.** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by **31 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 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	**SIGNED:**  **Mr Philip Spinney** **HM Area Coroner**