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: Michael Parke 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 13th December 2012 I commenced an investigation into the death of Michael Parke aged 40 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 following a misplaced nasogastric tube for treatment of gastrointestinal haemorrhage due to underlying alcoholic liver disease. 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. Michael Parke died at 13.10 on 6 December 2012 at the West Cumberland Hospital, Whitehaven, following the insertion of a nasogastric tube into his left lung resulting in Mr Parke developing aspiration pneumonia from which he 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 left lung instead of the stomach. In the course of the insertion resistance was felt. Trust policy required that where resistance was felt the nasogastric tube should be removed and reinserted. However the nasogastric tube was left in situ. An x-ray was taken in order to confirm the correct placement of the nasogastric tube. The x-ray clearly showed that the end of the nasogastric tube was situated in the left lung. The x-ray was mis-interpreted and feeding via the nasogastric tube was authorised. The failure to note this incorrect placement amounts to neglect. The Trust policy was inadequate and incorrectly assumed that doctors across the Trust were competent to interpret chest x-rays and failed to require doctors to either undertake training or to evidence their competence. The policy failed to require the completion of a sticker that included the anatomical 4 point checklist recommended in the 2011 NPSA alert. These failures amount to systemic neglect. 140 mls of medication and food was administered via the tube and

	entered the deceased's lung resulting in the development of the pneumonia as a result of which he died.
4	**CIRCUMSTANCES OF THE DEATH** Michael Parke suffered from chronic liver disease and was on 2nd November 2012 admitted to West Cumberland Hospital intensive therapy unit. On 5th November it was decided that a nasogastric tube should be fitted as part of his care. This was inserted the same day. An x-ray was taken to confirm the position of the tube. This image was later reviewed by a doctor who confirmed the tube was in the stomach and that feed could be administered. He subsequently deteriorated and when examined by a consultant the following morning the tube was found to be in the lung and was removed. His health did not improve and he died on 6th December 2012.
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) h) i) j) k) [redacted] l) I have also sent it to the persons named below who may find it useful or of interest. a) [redacted] b) c) d) GMC e) NMC f) [redacted] g) 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**