ANNEX A

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 **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of the Cwm Taf University Health Board**
1	**CORONER** I am Andrew Barkley, Senior 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 the 20th December 2016 I commenced an investigation into the death of Robert John Owens. The investigation concluded at the end of the inquest on the 29th March 2017. The conclusion of the inquest was that of a *narrative conclusion. "Robert John Owens died as a result of septic shock when fed through a misplaced naso gastric tube on the intensive care unit at the Prince Charles Hospital. Merthyr Tydfil in circumstances in which National Guidance of the placement was not followed".*
4	**CIRCUMSTANCES OF THE DEATH** Mr Owens was a 68 year old gentlemen admitted to the Prince Charles Hospital on the 27th November with back pain. Whilst in hospital he developed an acute kidney injury and respiratory failure and had to be admitted to the Intensive Care Unit on the 1st December 2016. He was fed through a Naso Gastric Tube. That became dislodged on the 13th December and was replaced on the 14th. An x-ray was taken to ensure the correct placement of the tube which was, it transpired, misinterpreted. Feeding commenced and he became unwell later that day and into the early hours of the following morning. A subsequent x-ray undertaken to check the position of a new Central Venous Line demonstrated a "whiteout" of the left lung field and the misplacement of the NG tube. Despite efforts to revive him his condition deteriorated and he passed away on the 16th December 2016.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The Cwym Taf University Health Board *Guideline Procedure for Naso Gastric*

	Insertion and Positional Confirmation 2009 had not been updated and reviewed. It was due for review in 2012. (2) Despite clear National Guidelines from the National Patient Safety Agency (NPSA) advocating the PH testing and x-raying of a patient after the insertion of a tube, these guidelines where never followed. The evidence revealed that it is common practice within the Health Board only to x-ray and not to follow the National Guidance of PH testing. (3) Contrary to the National Guidance it appears that the check list following insertion of a NG tube was not being followed either although this now represents the policy within the Health Board. The evidence revealed that the practice differs depending on the setting (ward or ITU) and no clear guidance is in place for the ITU setting which, it was suggested, was required because of the particularities of practice in that environment.
6	**ACTION SHOULD BE TAKEN** 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 30th May 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, Minister for Health Welsh Assembly Government and the family who may find it useful or of interest. 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	**4th April 2017** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**