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:** **Basildon Hospital**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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 3 June 2013 I commenced an investigation into the death of John Charles Leyin. The investigation concluded at the end of the inquest on 2 December 2014. The conclusion of the inquest was that Mr Leyin died as a result of a recognised complication of a necessary medical procedure. The cause of death was 1a) Iatrogenic lung injury 1b) nasogastric tube insertion 1c) intracerebral haemorrhage
4	**CIRCUMSTANCES OF THE DEATH** Mr Leyin was admitted to Basildon Hospital on 10 April 2013 suffering from a stroke. He failed to recover and there were serious difficulties with feeding arrangements. A PEG could not be inserted successfully and a nasogastric tube was in error placed into Mr Leyin's lung. He continued to deteriorate and died on 1 June 2013.
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) There was a failure on the part of the Hospital to ensure the dissemination of Trust Policy and NPSA Guidance to all staff. (2) There were weaknesses in the training systems in place (3) Checks were not made as to whether or not staff were up to date in their training for carrying out procedures such as the insertion of a nasogastric tube. (4) At any one time there seemed to be a lack of knowledge as to how many trained staff were on duty to carry out such procedures
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 **10 February 2015**. 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 – [redacted] and to the Care Quality Commission 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	**16 December 2014** **Caroline Beasley-Murray**