REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] East Kent Hospitals University NHS Foundation Trust Trust Office Kent & Canterbury Hospital Ethelbert Road Canterbury CT1 3NG
1	**CORONER** I am Rachel Redman, Senior Coroner, for the Coroner area of Central and South East Kent.
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 10th April 2013 I commenced an investigation into the death of William Albert Winter. The investigation concluded at the end of the inquest on 27th March 2014. The conclusion of the inquest was that Mr William Albert Winter died as a result of surgery for the repair of an abdominal aortic aneurysm.
4	**CIRCUMSTANCES OF THE DEATH** Mr W A Winter was admitted to William Harvey Hospital on 25th March 2013 after discharge from St Thomas' Hospital on 22nd March 2013 for the repair of an abdominal aortic aneurysm. He was admitted to the Clinical Decisions Unit at about 8pm at William Harvey Hospital and found in an unresponsive state with rigor mortis at approximately 5am on 26th March. Resuscitation attempts were abandoned soon after.
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. Mr Winter was admitted to the CDU at 8pm and the nursing staff were concerned that he had not been reviewed by the surgical team. They missed carrying out a second set of observations soon after 2am on 26th March 2013 owing to the pressures on them to care for other patients on the Clinical Decisions Unit. Mr Winter was found in a

	unresponsive state at approximately 5am on 26th March 2013 when efforts were made to resuscitate him during which it was noted that rigor mortis had already developed. I heard evidence that there were 19 admissions and discharges to and from the CDU overnight with 4 members of nursing staff. It was apparent that whilst keeping an eye on Mr Winter, they did not carry out a second set of observations when they should have done nor did they escalate their request for a surgical review. They were unfamiliar with how to do this.
6	**ACTION SHOULD BE TAKEN** This was the second inquest I have conducted in which someone has died in the CDU and had already developed rigor mortis when it was noticed that they were unresponsive. The first case touched the death of Beryl Hopper who died on 19th February 2013 whose inquest I closed on 5th March 2014. I am concerned that the staff on CDU are overlooking the needs of their patients owing to the pressures they face. However, I note in the After Action Review Report that lessons have been learnt and that the recommendations identified in the Report have already been actioned.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd June 2014. 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 Person:- [redacted] - niece of the deceased. 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	**Date : 7th April 2014** **Signed:**