REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. MAYDAY HEALTH CARE PLC**
1	**CORONER** I am Kate Thomas Assistant Coroner, for the coroner area of Mid Kent and Medway.
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 of March 2014 I commenced an investigation into the death of George Marks, Aged 93. The investigation concluded at the end of the inquest on the 5th of November 2014. The conclusion of the inquest was natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mr Marks was admitted in to A&E Dept on the 14th of February 2014 with confusion, immobility and a chest infection. He was prescribed anticoagulant medication as a precaution given his age and immobility. The diagnosis of DVT was confirmed on the 24th of February when scans showed he had a DVT in the leg and right sided thrombus in the pulmonary artery. On the 27th of February a decision was made to change the anticoagulant medication to Rivoroxaban - administered orally. On the 27th of February Mr Marks was cared for by the first of a succession of agency nurses from the Mayday Healthcare PLC. From the evening of the 28th of February until the 4th of March, when a Doctor finally noticed, Mr Marks had failed to be given his medication and in particular the Rivoroxaban which was located in a 'pod' beside his bed.

	Mr Marks declined and died on the 6th of March 2014. A Consultant Haematologist at the Inquest said that it was unlikely that a new embolism would have formed had Mr Marks been administered Rivoroxaban and further, that there was a very high probability that the new embolism caused or contributed to his death.
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) Agency staff failed to have an understanding of the basic policies and procedures in place when administering medication and / or where a patient refused to take such medication. 2) Agency Staff failed to have an understanding of the Drug Prescription Chart and / or failed to make any record, or any adequate record in the said chart 3) Agency Staff failed to have an understanding of the need to make a record and or any adequate record in the patients nursing notes, 4) Agency Staff failed to adopt the correct "Hand Over' procedure.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 the 13th April 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 : Maidstone and Tunbridge Wells Trust: [redacted] [redacted] (son 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	 **17th February 2015**