## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Chief Executive Maidstone & Tunbridge Wells NHS Trust** |
| 1 | **CORONER**<br><br>I am Patricia Harding, senior coroner for the coroner area of Mid Kent & Medway |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 17th June 2015 I commenced an investigation into the death of Matthew Crowley, 39 years. The investigation concluded at the end of the inquest on 17th February 2016. The conclusion of the inquest was that Matthew Crowley died at 06.47 on 10th June 2015 at Pembury Hospital following a transfer from Maidstone Hospital. He had presented to Maidstone Hospital at 17.08 on 9th June 2015 acutely unwell. Supportive treatment was given at 22.00 to which he initially responded but he thereafter deteriorated and supportive measures were not escalated. He succumbed to an overwhelming sepsis caused by a pseudoaneurysm of his left thigh which had developed as a result of intravenous drug abuse. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Matthew Crowley was brought by ambulance to Maidstone Hospital at 17.08 9th June 2015. He was triaged approximately 40 minutes later and found to have a PAR 5. He was first seen by a doctor at 19.28 and found to be septic with acute kidney injury, liver and respiratory failure. He had a mass in his upper thigh and an oedematous mottled leg. Supportive measures were not put in place until 22.00 as a result of difficulties in placing a peripheral line. Options were discussed to transfer him to a vascular centre, ITU or the surgical site of hospital at Pembury. He continued to deteriorate during this time, measures were not escalated. A decision was made 9 hours after his arrival to transfer him to Pembury. He died some 2 hours after arrival. A post mortem established the cause of death as 1a sepsis, 1b pseudoaneurysm left thigh, 1c intravenous drug abuse |
| 5 | **CORONER'S CONCERNS**<br><br>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 |

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| | circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) A Rapid Access Treatment Protocol (RATT) was not in operation as a result of a busy A&E department which was short staffed. This resulted in a delay in triage<br>(2) The patient was not seen by a doctor for 2 hours 20 minutes despite being PAR 5 and requiring therefore an immediate review by a senior doctor<br>(3) There was a delay in ownership and onward management of the patient which resulted in timely decisions not being made. On call consultants responsible for those decisions were not aware of the patient deteriorating because they did not personally review the patient and were not informed of, or did not secure updated information themselves of how acutely unwell the patient was.<br>(4) Despite a vascular site declining to accept the patient until his renal function was optimised and a CT angiogram performed, a delay was caused by enquiries being made whether a second vascular site would accept the patient<br>(5) The ITU of the hospital to which the patient was transferred were not informed of the transfer |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th April 2016. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] brother, CQC<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 2016** **[SIGNED BY CORONER]** |