REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Medical Officer Medway NHS Foundation Trust**
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 6th of May 2015 I commenced an investigation into the death of Jonathan Lewis Fry, aged 58 years. The investigation concluded at the end of the Inquest on the 29th April 2016. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On the 16th of April 2015 Mr Fry was admitted to the Accident and Emergency Department following an un-witnessed fall. He had a history of low blood pressure and was alcohol dependant with controlled diabetes. He was started on DVT prophylaxis although the probability of a DVT leading to a Pulmonary Embolism (PE) was considered low in someone with Chronic Liver Disease. He was diagnosed with a L1 compression fracture and was referred to the Orthopaedic Team for assessment. He was deemed not to be a trauma patient and accordingly was suitable to be admitted into the care of the Medical Team. This did not happen and he remained in the care of the Orthopaedic Team, the plan being that the Medical Team would both assess and advise on Mr Fry's clinical care plan. Mr Fry was admitted onto an orthopaedic ward. He did not have either a

senior review which was the practice, by any Consultant at any time from admission to his death (the Orthopaedic Consultant was sick with no locum cover).

On the 17th April at 10.25 am Mr Fry had a review by a Medical Registrar and an Orthopaedic SHO. A CT scan ordered of the chest abdomen and pelvis but this did not happen and there was no record that this omission was considered or followed up.

In the afternoon of the 17th April Mr Fry was reviewed by orthopaedic SHO.

The medical notes are unclear as to what reviews if any were had on the 18th of April. There is no sign of any Medical Team review and although evidence at the Inquest suggested that reviews would have taken place as this was routine. There were entries in the drug balance chart which suggested some review of Mr Fry's medications had taken place.

On the 19th April there was a SHO review by the Orthopaedic team – there is an entry (untimed) that a Medical Registrar saw Mr Fry.

The Critical Care Outreach Team (CCOT) reviewed Mr Fry at 11.16 as his News Score was scoring a persistent 9 – 10. A physical examination did not suggest a DVT or PE.

His demand for oxygen had risen but he was not in distress and a request for a Respiratory Team review was made – although this was not possible before his death. The CCOT worker was reassured that the Medical Registrar was there although it transpired he had been called away due to a Cardiac Arrest. Mr Fry was physically unwell but alert and talking. It was assumed that Mr Fry's oxygen demand had gone up due to the chest infection.

During the afternoon on of the 19th April his News Score rose to 11

He was seen again by CCOT at 11.30 pm and 1 am during the night of the 19th in to the 20th April. Mr Fry was peripherally cold and it was difficult to obtain an arterial reading. A SHO was consulted who advised that another attempt to obtain an arterial reading be made between 5 – 6 am and that IV fluids were to continue. Mr Fry again displayed no physical signs of a DVT or PE.

Shortly before 6 am on the 20th April the CCOT worker returned – she was told that at 5.10 there had been a drop in Mr Fry's oxygen saturations and a mask and then nasal oxygen had been administered and his oxygen levels had risen – he continued to have a news of 11. He was last observed at 5.45. At 6 am Mr Fry was found unresponsive and despite attempts could not be resuscitated.

	The medical cause of death after Post Mortem Examination was recorded as 1a) Pulmonary Embolism 1b) Deep Venous Thrombosis II Fracture of the Lumbar Spine
	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 no Senior review by a Consultant from admission to the time of his death and was no locum cover 2) There was no daily review of test results and no consideration given to instances where tests had not been performed or consoderation given to to the reasons why 3) Medical records were inconsistent and / or incomplete leading to a lack of clarity as to reviews and care plan.
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 12th June 2016, 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] - Next of Kin Department of Health 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	 **Kate Thomas** **Assistant Coroner** **16th May 2016**