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:** **1. Dartford & Gravesham NHS Trust** **2.** [redacted] **3.** **4.**
1	**CORONER** I am [Roger Linton Hatch, senior coroner, for the coroner area of North West 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 21st October 2016 I commenced an investigation into the death of Sian Marie Hollands]. The investigation concluded at the end of the inquest on 10th April 2017]. The conclusion of the inquest was The death of Sian Holland was due to the failures of the doctors at Darent Valley Hospital to examine, diagnose and treat her for pulmonary embolism following her admission to the hospital. The medical cause of death was Bilateral Pulmonary Thromboemboli.
4	**CIRCUMSTANCES OF THE DEATH** Sian Hollands became unwell on 14/11/2015. Her friend called an ambulance and she was taken to Darent Valley Hospital A & E, 18.38, She had complained of breathlessness, chest pain and feeling that she was withdrawing from opiates as she had not had methadone. Sian had also had surgery for an ectopic pregnancy at Ashford and St Peter's Hospital on 26.10,15. Sian was seen by an A & E doctor at 19.57. After taking her history and examining her the doctor arranged for her to have fluids and blood tests and then discussed her care with an A & E consultant and medical registrar. She remained in hospital for treatment with diazepam. In the early hours of 15.11.15 Sian complained of chest pain and wanted to see a doctor. The doctors were busy but advised she should have an ECG which she refused. She was seen at 10.30 by an A & E consultant who felt she was suffering from withdrawal and prescribed her methadone. She was reviewed again in the afternoon but was sleeping and therefore deemed suitable for discharge. Sian was seen by a physiotherapist who was unable to assess her mobility as requested because of shortness of breath and chest pain when trying to walk. The physiotherapist asked that she be reviewed again by a doctor. Sian was reviewed at approximately 1900 by the A & E consultant and who concluded that she may have a pulmonary embolus and transferred to resus for ongoing care. Sian suffered a cardiac arrest and death was confirmed at 21.52.

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The operating of the PAR scoring (now NEWS) and training of nurses and doctors (2) The failure of doctors to be provided with nurses medical notes (3) The failure of doctors to correctly diagnose pulmonary embolism
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 16th June 2017. 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 Dartford & Gravesham NHS Trust, [redacted] 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]** **20.04.2017** **[SIGNED BY CORONER]**