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. Chief Executive Officer Kent & Medway Social Care Partnership Trust**
1	**CORONER** I am Sonia Hayes assistant coroner, for the coroner area of Mid Kent & 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 20 November 2019 an investigation was commenced into the death of FRED MALCOM REYNOLDS (Ted), 90. The investigation concluded at the end of the inquest on 3 June 2021.The conclusion of the inquest was Narrative 'Ted was at risk of falls due to his low sodium, anaemia, increasing frailty and head injury, the combination of which contributed to his death'. The cause of death was 1a Acute on chronic subdural haematoma (operated on 7/9/19), 1b Head injury and II Anticoagulation for atrial fibrillation. Ischaemic heart disease due to coronary artery atherosclerosis. Chronic obstructive pulmonary disease.
4	**CIRCUMSTANCES OF THE DEATH** Ted died on 30th October 2019 at Kent and Canterbury Hospital of an acute on chronic sub-dural haematoma operated on 7th September due to head injury. Ted was admitted to hospital as an informal patient following a first onset of severe depression and self-harm. Ted had a history of low sodium and anaemia. He has CT scans that showed a non-progressive chronic bilateral sub-dural haematoma up to the 19th July following falls on the ward. Ted was transferred to acute hospital and diagnosed with syndrome of inappropriate antidiuretic hormone and infrarenal aortic aneurysm. A CT scan on 30th August found acute on chronic sub-dural haematoma with midline shift and small mass effect. Ted fell on the ward on 2nd September and exhibited new neurological symptoms with suspicion of progression. Ted underwent burr hole evacuation and had post-operative delirium and was transferred to Kent and Canterbury Hospital. The sub-dural haematoma affected his swallow and his delirium persisted. He commenced at risk feeding and was treated for chest infection. Ted sustained falls on the ward on 6th and 23rd October with stable CT scans but was increasingly frail. An advanced care plan was agreed and he remained on the ward. Ted was at risk of falls due to his low sodium, anaemia, increasing frailty and head injury, the combination of which 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 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. – Specialist neurology advice was given to conduct neurological observations every two hours for 48 hours following head injury. These observations were commenced but not continued. It was not possible to understand why these observations has been discontinued and there was no entry made in the medical records.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 9th September 2021. 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 Family, the Chief Coroner and to the following Interested Persons Maidstone & Tunbridge Wells NH Foundation Trust. I have also sent it to the Care Quality Commission who may find it useful or of interest. I am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	Signature: S. M. Hayes Sonia Hayes Assistant Coroner **Mid Kent and Medway** 15th July 2021