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 Medway NHS Foundation 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 23 March 2021 an investigation was commenced into the death of Johanna Marie MORELAND, 59. The investigation concluded at the end of the inquest on 6 July 2021. The conclusion of the inquest was 1a Intra-Abdominal Haemorrhage 1b Advanced Hepato Cellular Carcinoma following Biopsy Procedure Narrative - Johanna had advanced liver cancer and underwent biopsy on 4th March that hastened her death by a short time.
4	**CIRCUMSTANCES OF THE DEATH** Johanna Moreland died on 8th March 2021 at Medway Maritime Hospital of Intra-Abdominal Haemorrhage due to Advanced Hepato Cellular Carcinoma following a biopsy procedure on 4th March. Johanna was found in peri arrest at approximately 20:18 and given a transfusion. Johanna was not suitable for surgical intervention and continued to deteriorate.

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. – (1) Results from lumbar puncture taken on 26th February 2021 were made available on 4th March 2021. Evidence heard at the inquest was that Lumbar Puncture tests are usually for diagnosis of serious illness and would usually be made available within 24-48 hours. (2) The Lumbar Puncture results were positive for encephalitis and in the absence of the tests results, a liver biopsy was conducted and, there was a delay in antiviral treatment commencing. (3) The Trust policy on the required levels of observations following a liver biopsy were not followed on return to the ward due to a miscommunication between Trust staff and the required levels of observations was not recorded 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 5th 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 Chief Coroner and to the following Interested Persons [redacted] (Brother). 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** 11th July 2021