**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>Ms M Dinwoodie<br>Chief Executive<br>Kent Community NHS Trust<br>The Oast<br>Unit D<br>Hermitage Court<br>Barming Maidstone<br>Kent ME19 9NT |
| 1 | **CORONER**<br><br>I am Rachel Redman, Senior Coroner, for the Coroner area of Central and South East Kent. |
| 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 and 18th October 2013 I commenced an investigation into the death of Michael Longley. My summary of evidence and conclusion were read at Folkestone Magistrates Court on 18th December 2013 when the inquest ended. The conclusion of the inquest was a Narrative Verdict. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr M D Longley had an adverse reaction to Rivaroxaban which was administered after hip surgery which took place on 071211 at William Harvey Hospital, Ashford. Clexane was administered on 261211 by the district nurses. He was admitted to William Harvey Hospital on 311211 with an unrecordable platelet count and died the same day. |
| 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 circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>I heard evidence that Integrated Care 24 had difficulties in contacted the District Nursing Service on 25th December 2011 and I consider that improved methods of both oral and written communication between IC24 and the district nurses must be put in place. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>I consider the training of District Nurses must now include that a patient should be examined if symptoms of bleeding have been reported. |
| 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 12th February 2014. 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:-<br>AVMA<br>[redacted]<br>Gordons Partnership<br>RadcliffesLeBrasseur<br>Clyde & Co<br>Berrymans Lace Mawer<br>[redacted]<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 | **Date: 19th December 2013 Signed by**<br><br>**H M Coroner** |