Roger Linton Hatch
Senior Coroner for North West Kent

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Maidstone & Tunbridge Wells NHS Trust**
1	**CORONER** I am Roger Linton Hatch, Senior Coroner for 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. 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 29/04/2015 I commenced an investigation into the death of Sandra Rhoda Marion Wood, aged 69 . The investigation concluded at the end of the inquest on 10 February 2016. The conclusion of the inquest was Natural Causes as a consequence of the failure by the Tunbridge Wells Hospital to correctly diagnose and treat her on the 17th April 2015 On Friday 17th April 2015 Sandra Wood was sent by her General Practitioner to Tunbridge Wells Hospital with a suspected bowel obstruction from where she was subsequently discharged home with a diagnosis of UTI and constipation. On Saturday 18th April 2015 she was taken to Maidstone General Hospital after being found collapsed at home where she died later the same day. Cause of death found at post-mortem 1(a) Bowel Obstruction due to1(b) Adhesions
4	**CIRCUMSTANCES OF THE DEATH** As above
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 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) The NHS Trust does not have facilities for routine CT scans to be carried out during weekends (2) If an urgent CT scans are necessary a specific application procedure has to be put in place (3) In this case despite the requirements for an urgent scan to be undertaken in a potentially emergency situation the scan was to be delayed until after the weekend, which proved to be too late due to the fact that Mrs Woods died on Saturday 18th April 2015.

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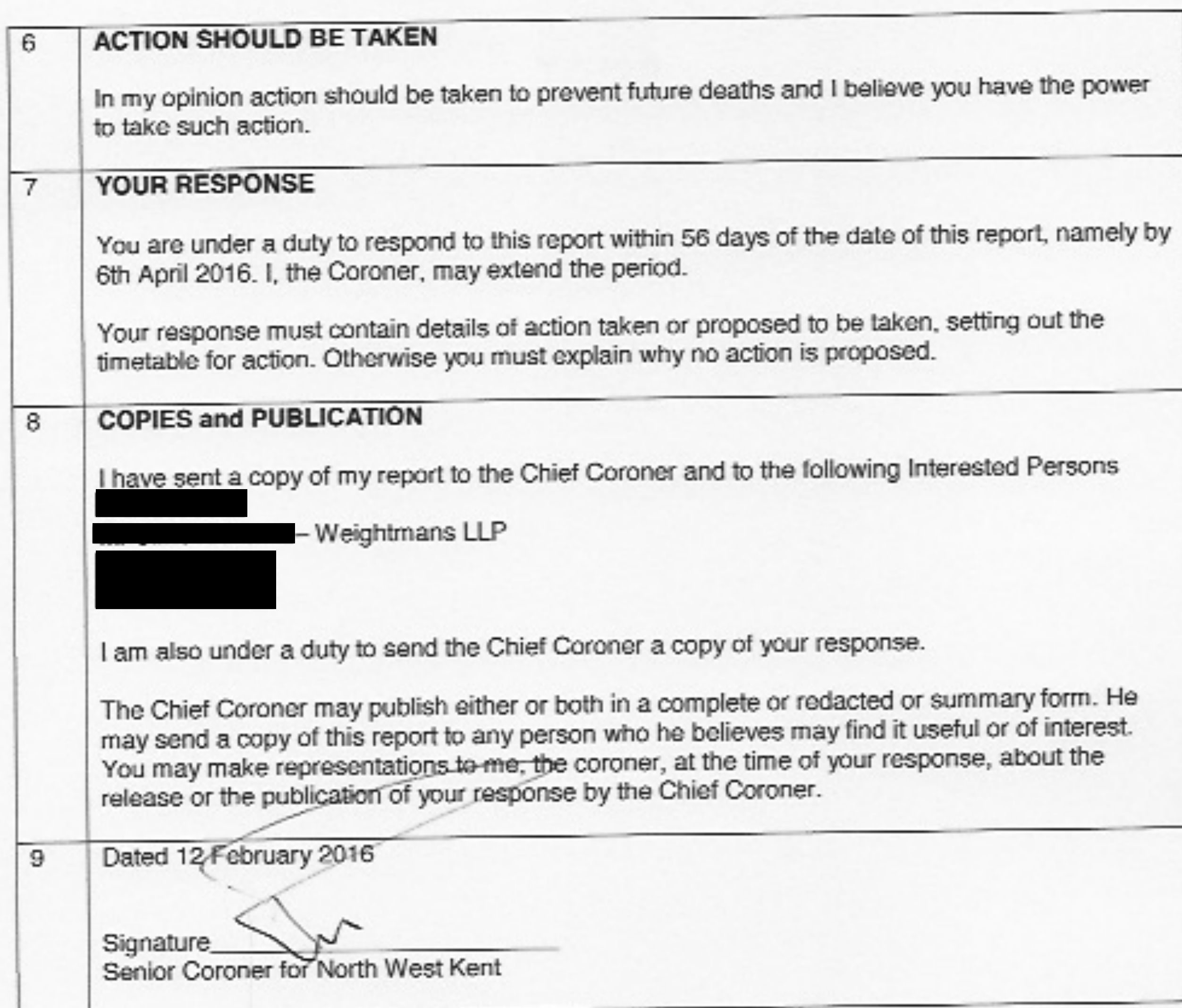

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th April 2016. I, the Coroner, may 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] [redacted] – Weightmans LLP [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	Dated 12 February 2016 Signature____________________ Senior Coroner for North West Kent

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