




Mid Kent and Medway Coroners

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Lesley Dwyer, Chief Executive Medway NHS Trust
1	CORONER I am Ian Wade QC Assistant Coroner for Mid Kent and 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 15th August 2017 I commenced an investigation into the death of John Edward LEE. The investigation concluded at the end of the inquest 17th October 2018. The outcome of the inquest was a Narrative describing the course of events leading to death from iatrogenic injury which included the conclusion that the blood loss was a recognised complication of necessary surgery. The medical cause of death was 1a Symptomatic Abdominal Aortic Aneurysm (operated)
4	CIRCUMSTANCES OF THE DEATH Emergency admission from Maidstone clinic on 24.07 with tender right iliac aneurysm 6.1cm and non tender AAA 4.6 cm. CT angiogram reviewed- not suitable for endovascular repair. Explained to patient, as tender, the next option is open repair. Patient was fully consenting and aware of risk associated with surgery. Patient taken to operating theatre and operation started as 16:45. On opening abdomen the patient's blood pressure became labile with low episodes even after clamping the aorta. Estimated 7 litres blood loss during whole operation and patient had 6 units of blood and 4 units FFP. Significant event during operation was at 20:26, patient went into ventricular tachycardia and cardiac output was restored by 1 episode of DC shock. While closing the retroperitoneum at 22:22 patient lost cardiac output and CPR started. 6 doses of 1mg adrenaline given with no response. At 22:37 the team decided not to continue and patient died at 23:00 on operating table.
5	<u>CORONER'S CONCERNS</u> 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. – John Lee developed an abdominal aortic aneurysm which had become enlarged. His GP wrote an urgent referral letter to the appropriate hospital specialist department requesting a vascular assessment. That letter was considered the next day by a specialist nurse at Medway Maritime Hospital, who after conferring with a consultant vascular surgeon graded the referral as urgent, endorsed the GP letter with the words "next vascular slot Maidstone" and passed that letter to a clerk or secretary to fix the appointment. The nurse's evidence was that the Trust had a policy to see such patients within 2 weeks,

	<p>that vascular clinics were conducted on a Monday and that therefore her intention had been that Mr Lee would be seen on the subsequent Monday. If that had been the “next” Monday, the appointment would have been within 5 days of grading. Due to a clerical error which was admitted but not explained, the secretary allocated Mr Lee to an appointment 5 weeks later than the “next” Monday. When Mr Lee attended that appointment, his aneurysm had become tender and the consultant admitted him for an emergency procedure. The next day Mr Lee died on the operating table, as a consequence of uncontrollable haemorrhaging and ventricular tachycardia, following otherwise successful reduction of the aneurysm and insertion of Dacron graft. Expert opinion was accepted to the effect that if Mr Lee had been seen within 2 weeks of referral as intended, he could have been managed as an elective procedure, allowing for early stopping of his Clopidogrel medication, better precautionary control of a cardiac arrhythmia and a less acute situation.</p> <p>(1) The use of the expression “next vascular slot” is uncertain and open to mis-interpretation (2) There should be provision for the direct input of clinical grade staff in setting clinical especially urgent appointments (3) There should be consideration given to a checking procedure to guard against human error or misunderstanding of priority</p>
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6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th December 2018. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] of Staplehurst Health Centre.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>19th October 2018</p> <p>Signature: </p> <p>Ian Wade QC Assistant Coroner Mid Kent and Medway</p>