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. The Chief Executive, Maidstone & Tunbridge Wells NHS Trust** **2. NHS England**
1	**CORONER** I am Roger Hatch, senior coroner, for the coroner area of Kent (North-West)
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 15th August 2018 I commenced an investigation into the death of Timothy Alastair Mason, aged 21 years. The conclusion of the inquest was that the medical cause of Timothy's death was 1a. Meningococcal Septicaemia. The narrative verdict was due to the failure to diagnose and treat Timothy at Tunbridge Wells Hospital and had he been correctly treated he probably would not have died. In addition, during the course of the investigation it was clear that Timothy had not been vaccinated with Men ACWY as his medical records confirmed. It appeared from the evidence that there were considerable concerns for the provision of the vaccination of people of Timothy's age, in the way they were informed of the availability of the vaccine, the computer records of the way GP's were informed and notified by NHS England and monitored and what steps are being taken to improve the system to ensure people are notified, advised and monitored to ensure they receive the vaccination in the future.
4	**CIRCUMSTANCES OF THE DEATH** On the 16th March 2018 Timothy had been unwell for several days and had been seen by his GP. His symptoms worsened, and he attended Tunbridge Wells Hospital at 3.30 am. He was given fluid resuscitation and antibiotics. At 07.45 he was seen by [redacted] and told he had a virus and was sent home. Timothy became worse and returned to the hospital on the same day at 15.15 where he was given treatment despite which he died at 21.46. In addition, it was clear from the evidence from [redacted] of the Saxonbury House Medical Group that Timothy had not received the Men ACWY vaccination it was unclear whether he had been invited to have the vaccination, or had been and decided not to. There seems considerable doubt as to how GP surgeries arranged for the vaccination and the way NHS England provided the program for the doctors and monitored the

	notification of the vaccine to ensure anyone of Tim's age would receive the vaccination..
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) The reasons for the failure to correctly diagnose and treat Timothy on the 16th March 2018 at 03.30. What staff instructions were given to the doctors and nurses in the Emergency Department at the hospital for dealing with patients with symptoms suggestive of sepsis and what tests should have been carried out and why they were not done. (2) Why was Timothy discharged home on the morning of the 16th March 2018 when he was clearly very unwell and tests had not been carried out. (3) What steps have been taken by the Trust to avoid this situation happening again to another patient in the future. (4) What training is being given to the doctors and nurses to avoid this situation in the future. (5) How it happened that Timothy did not receive the Men ACWY vaccination and what systems are in place to ensure patients do receive the vaccination, how this is provided and monitored by NHS England and whether this is adequate or should be improved to avoid patients failing to receive the vaccine. (
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe each of 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 20th December 2018. 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] Maidstone & Tunbridge Wells Trust and NHS England. I have also sent it to Saxonbury House Surgery who may find it useful or of interest. 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	**[DATE]** 26:X:2018 **[SIGNED BY CORONER]**