	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive Officer Medway Maritime Hospital**
1	**CORONER** I am Sonia Hayes 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 12th April 2018 I commenced an investigation into the death of Daphne WIGLEY. The investigation concluded at the end of the inquest 29th May 2019. On 20th March 2018 she was admitted to hospital with heart problems and a chest infection. Diagnosed with non ST segment elevated myocardial infarction and bilateral pleural effusion. Suffered nausea and fell on the ward at 14:45 on 22nd March hitting her head. CT scan showed subdural haematoma not for surgical intervention. Treated palliatively and died on the ward at 02:45 in the presence of her family. 1a **Acute Subdural Haematoma** b **Fall** c II **Myocardial Infarction, Heart Failure, Hypertension, Breast Cancer, Lower Respiratory Chest Infection, Arthritis, Hypercholesterolaemia** **Conclusion Accident**
4	**CIRCUMSTANCES OF THE DEATH** Admitted to hospital with progressive shortness of breath, cough with yellowish sputum and generalised weakness. Treated with oxygen, antibiotics, medications for non-ST Elevated myocardial infarction and heart failure. On 22/03/2018 at 14:45 suffered nausea and fell hitting her head. Reviewed immediately, neurological observation ordered and CT head scan completed. Reviewed again and later was noted to be unresponsive. Discussed with Kings College Hospital Neurosurgery severe traumatic brain injury and multiple co-morbidities and was not for neurosurgical intervention and was placed on palliative care and died on 23rd March 2018.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. The serious investigation report noted that neurological observations ordered were not in line with the hospital Green Book or the NICE guidelines and the recommendation to remind doctors of the guidelines was not completed. Although this did not contribute to this death, 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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) (2) (3)

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 14th September 2019. 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 [NAMES] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] 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	20th August 2019 Signature: S. M. Hayes Sonia Hayes Assistant Coroner **Mid Kent and Medway**