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. Chief Executive Officer Maidstone & Tunbridge Wells NHS FoundationTrust**
1	**CORONER** I am Sonia Hayes assistant coroner, for the coroner area of Mid Kent & 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 16th September 2019 an investigation was commenced into the death of KATHERINE MABEL HOGAN, 93. The investigation concluded at the end of the inquest on 17th July 2020. The conclusion of the inquest was 1a Bronchopneumonia 1b Subdural and Intracranial Haemorrhage Following a Fall II Pulmonary Embolism, Artery Atheroma Accident
4	**CIRCUMSTANCES OF THE DEATH** Katherine Hogan died on 31st August 2019 at Maidstone Hospital. She sustained a severe head injury and major haemorrhage due to a high impact fall from a trolley in clinical decision unit on 16th August 2019. She was treated conservatively. Staff shortages contributed to the fall.
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) Staff shortages contributed to the patient being left the clinical decisions area of the unit on a trolley. This was not an area that was suitable to keep a patient overnight. Staff shortages were reported to those responsible for the hospital. (2) Evidence is that the unit has moved and has been reconfigured, however there remains an outstanding request for increased staffing that has not been addressed by the Trust.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 11th January 2021. 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 Mrs [redacted] (daughter of Katherine Hogan). I am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	Signature: S. M. Hayes Sonia Hayes Assistant Coroner **Mid Kent and Medway** 18th November 2020