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 Medway NHS Foundation Trust**
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 19thNovember 2018 an investigation was commenced into the death of BETTY ANNIE TADMAN. The investigation concluded at the end of the inquest on 21st January 2021. The conclusion of the inquest was Fall Causing Pelvic Fracture with Extensive Local Haemorrhage 2 Haemorrhagic Cystitis and Gastritis, Dalteparin administration for suspected Deep Vein Thrombosis a Narrative.
4	**CIRCUMSTANCES OF THE DEATH** Betty Tadman died on 3rd November 2018 as a result of a fall at home on 2nd November 2018 that caused a pelvic fracture with extensive local haemorrhage. The fall was unwitnessed but likely occurred when Betty tangled her walking stick in her trouser leg. She was conveyed to hospital with a pre-alert for sepsis. She was unable to weight bear and her left leg was noted to be shortened, no scan or X-ray was conducted. Betty was treated for suspected urosepsis and also deep vein thrombosis with therapeutic dalteparin and continue to deteriorate. There was a missed opportunity to diagnose a pelvic fracture with internal bleeding that contributed to her death. It is unlikely Betty would have survived surgical intervention.

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. Mrs Tadman had dementia and a long-term catheter who was admitted to hospital with a pre-alert for suspicion for urosepsis that was treated appropriately. However, urine dipstick tests were only positive for blood and consideration was not given to the circumstances in which she was found with a history of a fall. 2. Evidence was heard at the inquest that ambulance crew noted and handed over Mrs Tadman's left leg was rotated but not shortened. Mrs Tadman could not stand or mobilise to use the commode in hospital. No consideration was given to a potential fracture injury. 3. Mrs Tadman was an elderly lady with a medical history of osteoporosis who fell from a standing height. No imaging was conducted on admission to hospital to establish if Mrs Tadman had sustained an injury. 4. Swelling in the calves gave rise to a suspicion of potential deep vein thrombosis and dalteparin was prescribed. Physical examination was over reliant on the lack of complaints of pain in a patient with dementia in the absence of imaging. 5. There was no consideration of potential fracture or internal bleeding in the presence of dropping of haemoglobin and continued deterioration. 6. The Trust did not conduct a serious incident investigation following Mrs Tadman's death when the post-mortem cause of death established a pelvic fracture with severe haemorrhage. Evidence heard at the inquest confirmed that this case was not discussed at the trust morbidity and mortality review or any other forum giving rise to concerns that lessons had not been learned.
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 28th March 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 [redacted] (daughter). 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	Signature: S. M. Hayes Sonia Hayes Assistant Coroner **Mid Kent & Medway** 1st February 2021