## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>The Chief Executive<br>Medway Maritime Hospital<br>Windmill Road<br>Gillingham<br>Kent<br>ME7 5NY |
| 1 | **CORONER**<br><br>I am Kate Thomas, assistant coroner, for the coroner area of Mid Kent and Medway |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 1st May 2018, I commenced an investigation into the death of Rodney Gates aged 84. The investigation concluded at the end of the inquest on 2nd March 2021. The conclusion of the inquest was<br><br>Misadventure contributed to by neglect |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 5th April 2018, Mr Gates crossed the A2 High Street, Newington Kent, passing in front of a HGV which was waiting at temporary traffic lights set up to manage traffic flow whilst the carriage way was excavated to repair a leaking water pipe.<br><br>As he crossed directly in front of the vehicle, it was beckoned forward by the traffic management operative, clipping Mr Gates' shoulder and causing him to fall to the kerb and sustain injury.<br><br>He was admitted to Medway Maritime Hospital by ambulance and was diagnosed with fracture of the right proximal femur, which was known to carry a high risk of bleeding, such risk being increased by reason of Mr Gates' age and coronary artery disease.<br><br>He was appropriately managed and admitted to the ward at approximately 1 am on the 6th April 2018, with a plan to operate later that day.<br><br>Throughout, Mr Gates's blood pressure had been low and although his NEWS score had been zero at the point of entry to the hospital it had risen to 3 at the time he was transferred to the ward.<br><br>It subsequently dropped to a score of 2 which pursuant to the NEWS protocol required 2 hourly observations as a minimum. In any event the observation rate had been set at every 2 hours by treating clinicians due to the need to monitor for any deterioration due to bleeding at the fracture. |

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| | Those observations were undertaken until 6.30 am on the 6th April 2018 after which they were not performed again until 1.15 pm ( nearly 7 hours later ) when it was recorded that Mr Gates' Blood pressure had dropped such that it was apparent that there was a significant and serious bleed from the facture site and which required immediate medical intervention. His deterioration during this 7 hour period had not been identified.<br><br>Despite appropriate management including transfusions Mr Gates continued to decline and arrested at approximately 3.45 pm and died despite resuscitation attempts.<br><br>The medical cause of death was<br><br>1a Hypovolaemic shock following recent osteoporotic comminuted fracture of the proximal right femur ( awaiting definitive treatment ) in a patient with coronary artery disease and myocardial infarction<br><br>II Hypercholesterolaemia, road traffic collision |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) the failure to undertake at all the required observations of a patient pursuant to clinical direction and / or the NEWS protocol which was directly attributable to the conditions of the nursing staff on the ward, those being -<br><br>(2) the overall low number of nursing staff both within the A&E department and on the ward<br><br>(3) the reliance on agency nurses<br><br>(4) the lack of experience and narrow spectrum of skill set of the nursing staff<br><br>(5) the lack of equipment available to nursing staff on the ward |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation] have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th May 2021 I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>[redacted] – nephew of the deceased and representative for the family |

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| | I have also sent it to the Department of Health and Social and the Care Quality Care Commission who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **8th March 2021**<br><br>  <br><br>**Kate Thomas**<br>**Assistant Coroner**<br>**Mid Kent and Medway** |