Mid Kent and Medway Coroners

Cantium House
2nd Floor
Maidstone
Kent
ME14 1XD

Telephone:
New and Current Cases: 03000 410502
General Enquiries: 03000 410503
Email: KentandMedwayCoroners@kent.gov.uk

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Chief Executive of the Medway NHS Foundation Trust
1	**CORONER** I am Ian Brownhill, assistant coroner, for the coroner area of 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.
3	**INVESTIGATION and INQUEST** Kathryn Lynda Millard died on 13 May 2021 at the Medway Maritime Hospital. An investigation into her death was commenced. The investigation concluded at the end of the inquest on 28 March 2022. The jury found that the medical cause of death was: 1a Pulmonary Embolism 1b Deep Venous Thrombosis 1c II Fractured Spine, Diabetes Mellitus The jury's conclusion was that Ms Millard's death was an accident. They gave a short narrative conclusion in addition, which read: She died from a complication of necessary medical treatment.

4	**CIRCUMSTANCES OF THE DEATH** On the 10th May 2021 Kathryn Millard fell backwards down a flight of stairs at a property where she was working. She was admitted to Medway Maritime Hospital with a fractured spine. At Medway Maritime Hospital, she was immobilised upon admission and a decision was made that she should be prescribed stockings to avoid deep vein thrombosis and dalteparin as prophylaxis. The stockings were not applied. In respect of dalteparin, this was decision was initially withdrawn due to an identified risk of bleeding and the prospect of surgery. When it was determined that there was to be no surgery, the treating consultant indicated that dalteparin should be commenced. That decision was not recorded in Mrs Millard's medical notes. The dalteparin was not given. On 12 May 2021, Mrs Millard began to have green vomit. The nursing staff were concerned and asked for her to be reviewed by a doctor. An unidentified individual came to the ward and saw Mrs Millard. That individual did not record their interaction in Mrs Millard's notes nor did they speak with the nursing staff. On the morning of 13 May 2021, Mrs Millard had a cardiac arrest. Despite efforts by staff, she could not be resuscitated.
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 direction of the most senior clinician, the orthopaedic surgeon, was not documented in the medical records and was not implemented. It is concerning that this treatment plan was not recorded properly in the deceased's notes. (2) The medical records indicated that at least one doctor had indicated that Mrs Millard should have anti-embolic stockings applied. However, the nursing staff gave evidence that they were not aware of this. (3) The nursing staff were concerned on the 12 May 2021 as to the presentation and prognosis of the deceased. Whomever attended (if they anybody did in fact attend), did not make any entry into Mrs Millard's medical records. It is concerning that the Trust were not able to identify this individual and that they did not discuss the patient's presentation and prognosis with the nursing staff.
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 **21 June 2022**. 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 The family of Kathryn Millard The other interested persons within the inquest The legal representatives of the above. In addition, I have sent this to: The Care Quality Commission 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: Ian Brownhill Assistant Coroner Mid Kent and Medway 25 April 2022