North East Kent Coroners' Service
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Date: 4 February 2025
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Secretary of State for Health and Social Care and [redacted], Chief Executive, NHS England

1. CORONER

I am Mrs. Catherine Wood, Assistant Coroner for North East Kent

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 26 April 2024 I commenced an investigation into the death of Dorothy Lilian REID. The investigation concluded at the end of the inquest . The conclusion of the inquest was a

Narrative "She died as a consequence of a pulmonary embolism which developed following period of reduced mobility due to a fall where she sustained thoracic and lumbar spinal fractures due in part to her underlying osteoporosis."

1a Massive Bilateral Pulmonary Embolism

1b Deep Vein Thrombosis

1c

1d

II Ischaemic Heart Disease, Atherosclerosis

4. CIRCUMSTANCES OF THE DEATH

Dorothy Reid was a 91 year old woman who had a medical history of osteoarthritis and osteoporosis as well as anxiety but was independent and living in an annexe of her daughter's home. She fell on 13 March 2024 and was seen in the minor injuries unit where she was assessed and sent home after her head wound was treated. She subsequently contacted her general practitioner who advised her to have an x-ray which was arranged for 21 March 2024. Spinal fractures were identified on the x-ray and she was referred to the emergency department at Queen Elizabeth the Queen Mother (QEQM) hospital and kept overnight before undergoing an MRI scan which confirmed the fractures and advice was sought from the regional neurosurgical department and advice given for her to mobilise and take analgesia. She was seen by an occupational therapist on 26 March 2024 who was concerned about her level of breathlessness and alerted her general practitioner. She was seen by the practice paramedic and gave a history of breathing difficulty after exertion for a few months, worse over the last couple of months and other than breathlessness on exertion she had no signs or symptoms requiring further treatment. On 31 March 2024 her daughter contacted the 111 service and an ambulance attended around 11pm by which time she was complaining of shortness of breath and had bilateral swollen feet and lower legs with no chest pain, but chest tightness after exertion. An ECG revealed widespread T wave inversion and although the ambulance crew advised that she should attend hospital she wanted to avoid a trip to hospital due to her previously having to wait in discomfort for hours and a referral was made to the out of hours general practitioner service instead. She was seen by a general practitioner on 1 April 2024 around 9.30am and gave a history of shortness of breath only on exertion and had bilateral swollen legs although denied chest pain or palpitations and the ECG taken by the paramedics was reviewed and noted. She was assessed and referred for further investigations and given advice to call an ambulance if her symptoms deteriorated. An ambulance was called just after 7pm on 2nd April 2024 and she was taken to Queen Elizabeth the Queen Mother hospital arriving shortly after around 9pm. She was triaged and left to wait in the waiting room as the department was busy. She deteriorated whilst waiting to be seen by a doctor and was transferred from the corridor to the RAT area and seen by a doctor who considered that she was very unwell and transferred her to the resuscitation department where she suffered a cardiac arrest. A return of circulation was achieved and a bedside echocardiogram was suggestive of a pulmonary embolus but it was thought she was unlikely to survive treatment and a decision was made to keep her comfortable and she died shortly after 3.30am on 3 April 2024. A post mortem confirmed a pulmonary embolus was the cause of her death.

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 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) During the course of the evidence it became clear that on both attendances to the emergency department at QEQM she had to wait on a chair as there were no beds. The first attendance led to such a poor experience that she chose not to go back to hospital when an ambulance was called on 31 March 2024. Had she gone to hospital on 31 March 2024 when advised to do so it is likely that her pulmonary embolus would have been diagnosed in the emergency department and treated and she would not have died when she did. Delays in being seen by a doctor at the second attendance were of concern but were found not to be

causative of her death.

(2) Both attendances at the emergency department were on busy shifts but evidence heard from staff was that this was not unusual and the reasons being that beds in the hospital are blocked by patients who are medically fit for discharge. The evidence heard was that on average around 25% of the hospital beds were filled with patients who did not need to be there which in turn leads to patients who need to be admitted not having a bed to be admitted into. This in turn leads to patients waiting in the emergency department for a bed. This places unnecessary pressure on the emergency departments and leads to delays for those seeking emergency treatment. The evidence heard suggested that this was a national not local problem.

(3) When asked about whether the delays led to a risk of deaths to others evidence was brought to the courts attention that the President of the Royal College of Emergency Medicine has published an analysis of the impact that this is having and that there are a significant number deaths associated with long waits in the emergency department. This, in conjunction with the reluctance of patients to attend the emergency department due to long waiting times clearly gives rise to a risk of future deaths unless something is done.

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 2 April 2025. 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 her family, East Kent hospitals NHS Trust and The Broadstairs Medical Practice.

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.

4 February 2025

Signature 

Catherine Wood Assistant Coroner for North East Kent