Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE
[redacted]

Date: 10 February 2026
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Secretary of State for Health and Social Care

Kent County Council

Medway Council

Kent and Medway Integrated Care Board

1. CORONER

I am Catherine Wood, Area Coroner for 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.

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 8 January 2025 I commenced an investigation into the death of Liam Andrew SUTTON. The investigation concluded at the end of the inquest on 7 January 2026. The conclusion of the inquest was

Narrative
'He died as a consequence of chest sepsis which developed following his discharge home on an increased dose of opiates after a left total knee replacement.'

1a Respiratory Distress Syndrome

1b Pneumonia

1c Recent total Knee Replacement Surgery and unintentional opioid toxicity

1d

II High body mass index and hypertension

4. CIRCUMSTANCES OF THE DEATH

Liam Sutton had a complex past medical history including obesity, type II diabetes mellitus, hypertension, hyperchoesterolamia, previous pulmonary embolism, chronic pain, anxiety, depression, gout and previous joint replacement as well as spinal surgery and chronic osteomyelitis of his clavicle requiring multiple procedures. As a result of his chronic intractable pain he was prescribed slow release opiates in the form of Buprenorphine patches as well as other analgesic agents in addition to medication for his other conditions. He used a walking stick to mobilise and was limited in his mobility due to the severe osteoarthritis he suffered from. He was booked for a total knee replacement at KIMS hospital in Maidstone on 9 December 2024 which was an uncomplicated procedure undertaken under spinal anaesthetic. His Buprenorphine patch had been removed prior to surgery and post operatively the anaesthetist advised keeping the patch on and he was prescribed Oxycodone a longer acting opiate and Oramorph to be given to manage his acute post operative pain. The former was changed to Morphine 20mg slow release at Mr Sutton's request but at an equivalent dose. His drugs to take home when he left hospital on 10 December 2024 included 10mg Morphine Sulphate modified release to be taken twice a day and Morphine Sulphate in the form of Oramorph 10mg/5mls to be taken up to 4 times a day for breakthrough pain. He was known to take the Oramorph by sipping the drug rather than as prescribed but the staff at the hospital were not made aware of this information.

He was found unconscious by his wife on the afternoon of 12 December 2024 and she called an ambulance. The ambulance crew gave him Naloxone which improved his level of consciousness, although he remained confused following this and he was taken to Medway Maritime hospital where he showed signs of sepsis likely due to pneumonia and he was showing signs of acute kidney injury. He was initially treated with intravenous antibiotics and fluids and supplementary oxygen. A pulmonary embolism was ruled out after investigations and despite treatment he remained confused and his condition fluctuated. He had remained monitored in the resuscitation department in Accident and Emergency and was transferred to the High Dependency Unit on the evening of 13 December 2024 and by the following day he became more agitated and required sedation to manage his presentation. His sedation was increased with little effect so a decision was made to transfer him to the Intensive Care unit so he could be sedated and ventilated which happened in the evening of 14 December 2024. On 15 December 2024 he had an increase in his oxygen requirement and a pneumothorax was seen on a chest xray and treated with a chest drain. His infection markers improved and his oxygen requirement reduced by 21 December so a sedation hold was tried but he needed to be re-sedated. On 22 December 2024 a second sedation hold led to a more appropriate response which led to him being extubated but he became quite tired and required reintubation after around 6 hours. On 23 December 2024 he spiked a temperature and an infection screen was undertaken and antimicrobials and antifungals were commenced. By 25 December 2024 his oxygen requirement had reduced and his inflammatory markers had improved and the decision was made to have another trial of extubation following which he became acutely unwell and a decision was made to reintubate him. During reintubation he suffered a cardiac arrest from which he could not be resuscitated and he died that afternoon.

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. –

The court heard at the inquest revealed that the resuscitation department where Mr Sutton was admitted was busy and the evidence indicated that this was and is almost a daily occurrence at the Trust. Mr Sutton remained in the Emergency department resuscitation area for longer than 24 hours and should instead have been transferred to a suitable bed in the hospital. The Intensivist who gave evidence was clear that he should have been transferred to the High Dependency/ Intensive Care department and that patients who are admitted in a timely manner have a much better chance of survival. This also means that bays in the resuscitation department are not free to admit or attend to new acutely ill patients arriving at the hospital.

The court heard that the main issue is trying to discharge a patient to a suitable area in the hospital to free up a cubicle or bay in the resuscitation department. This in turn is due to beds being occupied by patients who are medically fit to be discharged. On any given day we heard that up to a third of the hospital beds can be filled with patients who are fit to leave hospital.

The court heard that the main delay is in discharging patients to appropriate settings or placements and the Trust have taken all steps they can internally to improve the flow of patients through the hospital. From the evidence the court heard it would appear that those responsible for providing care in the community including both the social care providers and the community healthcare providers are not providing either timely appropriate care packages in the patient's home or a bed in an alternative placement be that a nursing home or residential home placement. The evidence suggested that where patients were self funding the delays in discharge were less acute.

This means patients are kept in hospital for longer and thus are more at risk of contracting hospital acquired illness themselves which could lead to their own death but are also blocking beds which are needed to treat patients who require acute care in a suitable setting. This is leading to patients being kept longer in the emergency department and reducing available space to receive new critically ill patients. Both of these options can lead to death and there is clearly a risk of death for others requiring clinical care in an acute hospital

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the Secretary of State for Health, Kent County Council, Medway Council and Kent and Medway Integrated Care Board 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 8 April 2026. 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], Medway NHS Foundation Trust, KIMS and [redacted]

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.

10 February 2026

Signature [redacted]

Catherine Wood Area Coroner for Kent and Medway