## 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>**1 .Mr John Adler, Chief Executive University Hospitals Leicester,(UHL)**<br>**2. Mr Simon Stevens, Chief Executive NHS England,**<br>**3. Ms Sue Noyes, Chief Executive East Midlands Ambulance Service.** |
| 1 | **CORONER**<br><br>I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire South |
| 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. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 17 February 2015 I commenced an investigation into the death of George Boulton.<br><br>At inquest the determinations were that Mr Boulton had an intracerebral bleed at home on 12 February 2015; a spontaneous event. There was a delay in arranging this transfer to hospital during which time he erroneously received an injection of deltaparin... this action was material in the bleed continuing and he died on 14 February 2015 in Leicester Royal Infirmary from the consequences of this.<br><br>Cause of death<br>1a Left intracerebral haemorrhage |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Boulton was being cared for at home when he started to display symptoms of unsteadiness and difficulty in walking. The GP attended on request, and diagnosed probable stroke, and attempted to get the patient admitted to the local stroke team via bed bureau. There were no beds immediately available.<br><br>There was a delay in the ambulance arriving and therefore in admission as the request was not listed as an emergency, notwithstanding the diagnosis. In this case, during that time delay, the District Nurse attended for a routine daily appointment to administer daltaparin, an anticoagulant medication, and no communication had been made between the GP and community services to ensure this was not given, pending further investigations.<br><br>On admission to hospital, haemorrhagic stroke was confirmed by scan. It was not possible to adequately reverse the effects of the daltaparin, and this materially contributed to the ongoing bleed. |
| 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 |

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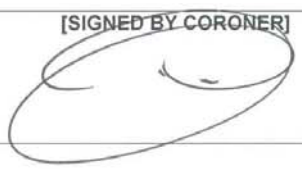
| | circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1. It was recognised by all witnesses to the inquest that response to potential stroke symptoms should be on an emergency basis, in accordance with "FAST" criteria ie a timely response. The GP attempted to arrange admission but accepted delays via bed bureau rather than convert to a 999 call and obtain immediate ambulance transfer.<br><br>2. The bed bureau did not appear from the evidence available in court to have a system for identifying calls that should have been re-routed to an emergency admission, and not be dependent on a bed, as early scanning was essential for proper diagnosis.<br><br>3. East Midlands Ambulance Service did not identify that a request to collect a stroke patient should have been escalated to a medical emergency and a 20 minute response time, rather than the actual allocated 2 hour response time.<br><br>4. This culmination of events in this particular case allowed for the unexpected intervention of the District Nurse: while this is very case specific, similar delays in another patient's care may allow further deterioration and the loss of treatment options. |
| | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st August 2015. 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: [redacted] (Wife), [redacted] (Son), [redacted] (Son), Mr J.Boulton (Son), [redacted] (Daughter).<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 | **[DATE]** 6/7/15 **[SIGNED BY CORONER]**  |