	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **East Midlands Ambulance Service c/o Freeth Cartwright Solicitors** **Kettering General Hospital NHS Trust**
1	**CORONER** I am Hassan Shah, Assistant Coroner for the coroner area of Northampton.
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** The investigation commenced on the 19th February 2015. A post mortem was conducted by [redacted] Consultant Histopathologist. Further evidence was obtained in relation to the deceased's background and medical treatment by paramedics and hospital staff. East Midlands Ambulance Service provided a "Description and Consequences report". The resumed inquest took place on the 18th June 2015. The GP's evidence was read under rule 23. Live evidence was taken from: 1. [redacted] Orthopaedic registrar at Kettering General Hospital 2. [redacted] Assistant Director of the Operations Centre for EMAS 3. [redacted] (deceased's son) 4. [redacted] Consultant Histopathologist The finding at inquest was that on 30th January 2015 at 22.10 hours, the deceased had a fall at her home. An ambulance conveyed her to Kettering General Hospital where death was confirmed at 02.26 hours on 31st January 2015. A narrative conclusion was delivered in the following term "*Mrs Withers' death was accidental however her death was contributed to by neglect. The 2 hour 50 minute delay between the 999 call being placed and the paramedic arriving probably did on the balance of probabilities contribute to Mrs Withers' death*"
4	**CIRCUMSTANCES OF THE DEATH** Mrs Withers was 77 years of age. She suffered significant medical problems and required constant home oxygen. Mrs Withers was attended at home by carers and the Rocket team. Mrs Withers suffered a fall sustaining injury and was immobile and unable to make telephone calls. A lifeline was activated. The paramedics arrived after a delay of 2 hours and 50 minutes. The Pathologist's findings were that the deceased suffered a fracture of the left pubic ramus as a result of a mechanical fall. This led to a significant blood loss into the soft tissues and the consequence of this significant haemorrhage resulted in cardiac arrest.

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 policy in relation to obtaining a patient's medical history during the first 999 call, reporting an incident. 2) The policy in relation to calling back a life line/third party where the patient is unable to receive calls. 3) The policy/procedure in relation to saving essential patient medical history in the ambulance service electronic data systems. 4) The policy in relation to staff abstraction tolerance and levels. 5) The policy and protocol in relation to hand over times between East Midlands Service paramedics and Kettering General Hospital Accident and Emergency staff (the concern being the apparent loss of time by ambulance staff during the handover of patient to hospital.)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation, 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 Wednesday 7th December 2015. 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] **Freeth Cartwright Solicitors** Similarly, you are 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.
9	**[DATE]** **12th October 2015** **[SIGNED BY ASSISTANT CORONER]**