REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Mr Richard Henderson, Chief Executive, East Midlands Ambulance Service NHS Trust**
1	**CORONER** I am Mrs Heidi Connor, assistant coroner, for the coroner area of Nottinghamshire.
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** On 10 March 2016 I commenced an investigation into the death of Dipa Rameshchandra Lad, DoB 27.3.79. The investigation concluded at the end of the inquest on 24 January 2017. The medical cause of death was ligature pressure to the neck. The conclusion of the inquest was Accident, together with a completed jury questionnaire.
4	**CIRCUMSTANCES OF THE DEATH** Dipa Lad was a 36 year old woman. She was born on 27 March 1979. We heard that she had been diagnosed with paranoid schizophrenia. As a result of a criminal conviction, Dipa was detained under the Mental Health Act. At the time of her death, Dipa was living at the Wells Road Centre in St Ann's, Nottingham. Most of the evidence we heard related to her mental health management. Dipa used an item of clothing to ligate on 4 March 2016. When ambulance staff attended, staff had been giving her CPR for approximately 15 mins. An AED had advised no shock to be given, and she was asystolic when crews used their manual defibrillator. Resuscitation efforts were started following the attendance of 2 crews (including an experienced paramedic) at around 2019 hrs. I/V access was not achieved. A paramedic team leader attended at 2024 hrs, and resuscitation efforts stopped at around 2027 hrs. The diagnosis of death form gives the time of death as 2028 hrs. We heard evidence about a key difference in the national guidance and local protocol for recognition of death. These documents are : 1. The National, JRCALC guideline, entitled 'Recognition of Life Extinct by Ambulance Clinicians', which in this scenario would have required 20 minutes of Advanced Life Support. 2. EMAS protocol entitled 'Diagnosis of Death Procedure', which in this scenario we were told would allow resuscitation to be stopped without 20 minutes of ALS – ie where resuscitation efforts are thought to be 'futile'.

	The EMAS protocol was updated in February 2016, less than a month before Dipa's death. The evidence was clear from the outset that nothing the ambulance crews did would have changed the outcome for Dipa. My concerns in this respect relate purely to risk to other patients in future as a result of the issues which arose during this inquest. I have summarised these below.
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. – 1. Is the EMAS deviation from national guidance safe as it currently stands? I do not know if this is a protocol adopted by other ambulance services around the country. I have copied the AACE into this report largely with this issue in mind. 2. The distinction between national guidance and local protocol is that EMAS crews may deem a resuscitation effort to be 'futile'. This is a clear and important deviation from national guidance, yet staff have been given no guidance about what a 'futile' resuscitation is. Whilst this may be clear in some situations, the protocol, if adopted, should give guidance where a situation is less clear – and perhaps consider providing that where there is any doubt, that full ALS protocol should be applied. As it currently stands, the protocol places a large burden on staff to ascertain 'futility' with no guidance whatsoever. 3. It was clear that most of the staff attending this emergency were not aware of the change in local policy. On arrival of the team leader (who told us she was aware of the protocol), resuscitation efforts were stopped. I am concerned about the clear disparities in awareness of this important change to protocol. 4. We heard that EMAS relies on emailing changes in protocols to staff. There is no check that busy staff have read and understood these, and there has been no training on this change. 5. We heard that staff carry JRCALC pocketbooks as reference guides. EMAS policy around diagnosis of death differs in a key respect from JRCALC guidelines – but there is no equivalent pocketbook / amendment to existing pocketbook / similar which reflects local policies. 6. I do not consider the current EMAS 'Diagnosis of Death Procedure' to be sufficiently clear / consistent (particularly when comparing the wording and the flow - charts). This also contains no guidance on when resuscitation should be considered 'futile', as referred to above. 7. One of the technicians who attended gave chest compressions standing up – with both feet on the same side of the patient. The reason she gave for this was not wanting to get blood from the scene on her trousers. She was not in a confined space, and when challenged by her team leader subsequently, used a towel to protect her clothes and continued to give compressions kneeling down. I am concerned to ensure that staff are trained / reminded of the best technique to give effective compressions – for the patient and for staff resilience reasons.
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 28 March 2017. 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 : 1. Legal representative for family. 2. Legal representative for the mental health trust where Dipa died. I have also sent a copy to the Chief Executive of the AACE, and to the legal representative who represented your trust at the inquest. 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.
9	**31 January 2017**