IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Keith William Rushton
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Chief Executive - West Yorkshire Ambulance Service NHS Trust and the** **Secretary of State for Health, Department of Health**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 22/12/2016 opened an inquest into the death of **Keith William Rushton** who, at the date of his death was aged 78 years old. The inquest was resumed and concluded on 31/8/2016. I found that the cause of death to be: - 1a Multi Organ Failure 1b Rhabdomyolysis II Long Lay, Obesity, Atrial Fibrillation and Right Heart Failure I concluded with a narrative conclusion:- On 16/12/2015, Keith William Rushton was found collapsed at his home address where he had been for 20 hours, after sliding out of bed and unable to get up. When taken to hospital, notwithstanding treatment, he succumbed and died from crush injuries to his legs later the same day. Although it is found that there had been a delay in the arrival of the ambulance, it is more likely than not, that an earlier arrival time would not have made a difference to the outcome.

4	**CIRCUMSTANCES OF THE DEATH** At approximately 8pm 15/12/2015, Mr Rushton who was morbidly obese slid from his bed at his home address onto his knees. Since he was unable to get up he remained in this position until he was discovered collapsed and conscious by his friend and neighbour at approximately12.30pm the next day of 16/12/2016. Although the ambulance was called at 12.53pm and coded Green 4, the ambulance did not arrive until 2.55pm, 2 hours and 2 minutes later. Upon the arrival of the paramedics Mr Rushton was taken to hospital, where notwithstanding treatment, he succumbed and died from Multi Organ Failure as a result of Rhabdomyolysis from the crush injuries to his legs as a result of his long lay the same day.
5	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is as follows:– • To review and reconsider the adequacy of the existing response times given the two hour delay in responding to Mr Rushton. • To review existing protocols governing the collation of information by telephone operators to incorporate more comprehensive enquiries with respect to long lays, particularly in the case of obese patients, in order to more effectively determine issues of priority for appropriate ambulance response times.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that West Yorkshire Ambulance Service NHS Trust has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date, I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to:-

	• [redacted] (son) • Secretary of State for Health, Department of Health • Chief Coroner
9	**DATED this 13/9/2016** M. D. Fleck