REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted]**NHS England** **Quality and Safety Manager** **NHS England South (SW)** **4th Floor** **South Plaza** **Bristol** **BS1 3NX** 2. **Ken Wenman – Chief Executive** **South Western Ambulance Service NHS Foundation Trust** **Abbey Court** **Eagle Way** **Exeter** **Devon** **EX2 7HY**
1	**CORONER** I am Dr Elizabeth Ann Earland, Senior Coroner for the Exeter and Great Devon District
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 20th July 2016 I commenced an investigation into the death of Colin James SLUMAN, 68 years old. The investigation concluded at the end of the inquest on 7th June 2017. The conclusion of the inquest was a Narrative verdict. Medical Cause of Death was established: Ia) Exsanguination Ib) Ulcerative Varicose Vein Right Calf Ic) – II) Cirrhosis and Obesity
4	**CIRCUMSTANCES OF THE DEATH** The Deceased suffered from varicose veins and shortly before 01:36 hours 15 July 2016, when he called for an ambulance, having had a vein burst as he scratched it, he then exsanguinated before emergency services attended at 03:03 hours at [redacted]
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) The protocol supplied by NHS Pathways to South Western Ambulance Service Trust (SWAST) call handlers does not include reports of "dizziness" and "patient on their own" as important triggers for a rapid response to a report of catastrophic haemorrhage. (2) Call handlers are not clinically trained and are completely reliant on the Protocol for categorising responses (in this case amber was used). (3) There are not enough Clinical Supervisors available to call handlers for advice (on appropriate response) at all times, nor do they have constant oversight of all emergency reports.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 15th August 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, Claims and Inquests Manager [redacted] (Next of Kin). 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	**Date** 21st June 2017 **Signed** ..... **Dr Elizabeth A Earland MB.Ch.B., D.A.,Dip.Law,L.P.C,Hon.LLD** **HM Senior Coroner** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon EX2 4QD**