REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, West Midlands Ambulance Service NHS Foundation Trust** **2. Chief Coroner**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 10 July 2017, I commenced an investigation into the death of the late Mr Reginald Dixon. The investigation concluded at the end of the inquest on 4 September 2017. The conclusion of the inquest was a short form conclusion of accidental death. The cause of death was: 1a Aspiration Of Gastric Contents b Subdural And Traumatic Subarachnoid Haemorrhage c Skull Fractures And Cerebral Contusions II Systemic Hypertension, Left Clavicle, Left Rib And Left Neck Of Femur Fractures
4	**CIRCUMSTANCES OF THE DEATH** i) On the 26th June 2017 at 1853 hours a 999 call was received by West Midlands Ambulance service (WMAS) to reports of a 70-year-old male, Mr Dixon who had an unwitnessed fall downstairs sustaining a head and back injury. ii) Initially it was reported the patient was conscious and breathing. The location of the incident was in Norton, Stourbridge. The call was triaged through Pathways and a category 3 response assigned. At that time, there was no available resource to immediately assign to the case. iii) At 1921 hours a second 999 call was received for the patient and this to was triaged through Pathways and a category 3 response assigned. It was reported that the patient's condition had changed and they were now vomiting and becoming drowsy. There was still no available resource to immediately assign to the case. iv) At 1931 hours a third 999 call was received for the patient and it was reported that the patient's condition had deteriorated further and following triage a category 2 response assigned. An ambulance was assigned to

	the case within 4 minutes but was some distance away from the incident. v) At 1945 hours a fourth 999 call was received and during this call the ambulance arrived on scene at 1950 hours, 57 minutes from the time of the original call. vi) The patient was found by the ambulance crew with a lowered conscious level and multiple injuries. Following assessment, the patient was conveyed to the major trauma centre during the transfer the crew were intercepted by the MERIT team, who anaesthetised the patient prior to continuing to hospital. vii) He was taken to Queen Elizabeth Hospital, Birmingham where it was identified the patient had an un-survivable head injury and wasn't deemed suitable for neurosurgery and sadly passed away the same day.
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. Firstly, evidence emerged during the inquest that the second call received by the WMAS operator at 1921 hours had been incorrectly triaged as Level 3. The evidence of vomiting and drowsiness should have resulted in a Level 2 categorisation and therefore faster response time. 2. Evidence also emerged during the inquest that there were insufficient resources available and average response times of 29 minutes. This delay posed a risk to patients.
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. 1. You may wish to consider further training of those staff involved in triaging response calls given the issues identified. 2. You may wish to consider further consultation with the Clinical Commissioning Group(s) in relation to the level of resource provided to deal with the Black Country population in light of insufficient resources being available in a timely manner as identified during this inquest.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 November 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; Family. 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	**15 September 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**