Thomas Ralph Osborne
Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive South Central Ambulance Service**
1	**CORONER** I am Thomas Ralph Osborne, Senior Coroner for Milton Keynes
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29th March 2017 I commenced an investigation into the death of Pamela Mary Pritchard, 88. The investigation concluded at the end of the inquest on 13th July 2017. The conclusion of the inquest was the she died as the result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Pritchard had had a recent stay in hospital due to her chronic obstructive pulmonary disease and was discharged home 5 days prior to her death. On 27th March her health began to deteriorate and her GP was called. He attended the home address at 13.45 and assessed that she needed to go to hospital and arranged for an ambulance. The ambulance did not arrive. Several calls were apparently made to chase the ambulance but the response was that the ambulance service was busy. Later that evening, at approximately 2150, the deceased's condition worsened and her daughter telephoned 999. The deceased died during that phone call.
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) That a GP with over 30 years experience had attended upon the deceased and his view was that she needed to be conveyed to hospital within four hours. When the four hours had expired a family member of the deceased was spoken to by a non medically qualified "call taker" who disregarded the previous instruction from the doctor. (2)That when the family made three emergency calls to the ambulance service the "call taker" made the decision not to escalate the priority of the call without seeking advice from a qualified practitioner. (3) That when an ambulance was not available to respond to the original call from the GP, the ambulance service did not make enquiries with the two adjoining ambulance areas namely East Midlands and East of England, to enquire whether a local ambulance was available to respond. (4) That a similar episode had occurred involving the same patient on the 16th February 2017 when the GP had requested a response within 2 hours. The service failed to meat this target by 3hours 42 minutes.

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 12th September 2017, 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 • The family of Mrs Pritchard • [redacted] • Care Quality Commission 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	Dated 19th July 2017 Signature_____ Senior Coroner for Milton Keynes