REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Chief Executive, NHS Hardwick CCG, Scarsdale Hospital, Nightingale Close, Off Newbold Road, Chesterfield, S41 7PF 2. The Chief Executive, East Midlands Ambulance Service NHS Trust 1 Horizon Place, Mellors Way, Nottingham, NG8 6PY
1	**CORONER** I am RACHEL SYED, Assistant Coroner, for the Coroner area of DERBY & DERBYSHIRE
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 14 December 2017, an Inquest was opened into the death of BERNARD LESLIE GERRARD which was concluded on Wednesday 28th February 2018. The conclusion of the inquest was Natural Causes and the medical cause of death being 1a. Bronchopneumonia, 1b. Chronic Obstructive Pulmonary Disease, II. Left Fracture Neck of Femur. During proceedings, the Court heard Pathology evidence which confirmed that the bronchopneumonia caused by the underlying Chronic Obstructive Pulmonary Disease had resulted in Mr Gerrard's fall.
4	**CIRCUMSTANCES OF THE DEATH** Mr Gerrard sustained injuries following an unwitnessed fall which occurred in his bedroom at around 5pm on 28 November 2017 at the Milford Care Home where he resided. The care home buzzer was activated and the person that discovered Mr Gerrard, dressed his arm wound whilst waiting for other carers to attend. During this period, Mr Gerrard was not noted to be in any pain and there was no shortening of the limbs. 111 was called to request the attendance of the District Nurse. Mr Gerrard was reassessed by care home staff, moved off the floor into his armchair using the hoist and was noted to sound breathless, also indicating to staff that his thigh was sore. At 17:40, 111 called back and were informed of Mr Gerrard's breathlessness and his inability to stand. The care home were advised not to move Mr Gerrard further until the ambulance arrived on scene. According to the Care Home Investigation Report, they had contacted East Midlands Ambulance Service at 18:45, 20:45, 23:11, 03:47 before an ambulance finally arrived on scene at 05:30 on 29 November 2017. Mr Gerrard was transported to Royal Derby Hospital for treatment and care where investigations revealed a Left Fracture Neck Of Femur. Despite the best efforts of his treating clinicians, Mr Gerrard died on 02 December 2017. The care home raised concerns that it had taken 12 hours for an ambulance to respond to Mr Gerrard. The Court heard evidence from an East Midlands Emergency Operations Centre Quality, Audit and Compliance Clinical Lead, that there had been a 10 hour delay in

	responding to Mr Gerrard, stating the initial 111 referral call, had been time stamped at 18:19 and correctly categorised as a Category 3 response, meaning that a conveying vehicle should respond within 2 hours, in 9 out of 10 cases. East Midlands Ambulance Service (EMAS) conceded at the latest an ambulance should have arrived on scene by 20:19. During evidence, EMAS explained that they had received 3 calls from the care home, at 19:44, 20.58 and 23:07 and a clinician call back had been undertaken at 20:40 confirming there were vehicle shortages resulting in ambulance delays. During the call they advised the care home to monitor the patient's condition and if there was any deterioration, EMAS should be re-contacted. At 03:10, EMAS correctly re-graded Mr Gerrard's condition to a Category 2 response, meaning that a conveying vehicle should respond within 18 minutes in 9 out of 10 cases, to reflect his breathing deterioration. EMAS accepted that the upgraded response should have resulted in an ambulance arrival by 03:30 at the latest. An ambulance finally arrived on scene at 04:20, some 10 hours after receiving the initial 111 referral. The Category 3 and upgraded Category 2 responses both fell well outside of the National Response Standards required. EMAS stated that the reasons for the delays were that they had no available resources to deploy due to high Service demands. EMAS accepted that the vehicle response time was unacceptable and stated that the Service could not cope due to insufficient resources and lack of funding. EMAS stated that during the period in question, they were holding three Category 2 calls and eleven Category 3 calls. When asked if these callers had also been waiting over 9 hours for a vehicle response, the reply was probably. EMAS went on to explain that they received the third lowest amount of ambulance funding in the Country which had recently been debated at Parliamentary level and without further funding they could not function.
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 could 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) There was a 10 hour vehicle response delay to attend to a Category 3 call. When the call was eventually upgraded to a Category 2 response, there was a further 50 minute delay. EMAS report that they cannot cope with the current demands placed on their service due to insufficient funding which is resulting in unacceptable vehicle response times
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 **Thursday 03 May 2018**. 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

	[redacted] **(Family)** 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	**08 March 2018** Rachel Syed **Rachel Syed, Assistant Coroner for Derby and Derbyshire**