REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Darren Mochrie** **Chief Executive** **South East Coast Ambulance Service** **SECAmb HQ,** **Nexus House,** **Gatwick Road,** **Crawley,** **West Sussex,** **RH10 9BG**
1	**CORONER** I am **PENELOPE SCHOFIELD**, senior coroner, for the coroner area of **WEST SUSSEX**
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 16th January 2018 I commenced an investigation into the death of **MARGARET STEMP**, aged 91. The investigation concluded at the end of the inquest on 11th June 2018. The conclusion of the inquest was that "Margaret died from natural causes following a long lie on the floor where there had been missed opportunities for medical intervention."
4	**CIRCUMSTANCES OF THE DEATH** During Christmas 2017 Margaret was staying with her sister who was 97 years old. It appears that around 4.00pm on 27th December both sisters had fallen over and were unable to get up. As a result Margaret's sister contacted the emergency services and an Ambulance was requested. The Ambulance service was under extreme pressure that day and were unable to send an Ambulance to assist these ladies. As the Ambulance service had not arrived after 7 hours the Police attended and assisted the two ladies and got them off the floor. The Police however indicted to the Ambulance service that they should still attend to check over these two ladies. Despite this at 2.00 am the following morning the Ambulance service, who has still not attended, made a further welfare telephone call to the address. They spoke to Margaret's 97 year old sister. She advised the Ambulance service that she had been waiting for the Ambulance service for a considerable period of time since and she was now going to bed and no longer needed them. The Ambulance Service closed the call without any clinical oversight of that decision. On 28th December a carer attended the sisters' address. When she arrived she discovered both ladies again on the floor. Sadly Margaret was found deceased and her sister needed to be taken to hospital.

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 there were insufficient resources to deal with the high number of calls on this day which meant that these two ladies were left on the floor for over 7 hours and what would have been considerably longer had the Police not attended. (2) That the Police had to be used to provide the necessary welfare support to these ladies (3) That the call takers did not seem to appreciate the worsening condition of these two ladies during the time they were seeking assistance. (4) That there was no clinical oversight of the decision to stand the Ambulance down despite knowing i) the age of these two ladies ii) the fact that they were vulnerable iii) that they had fallen and iv) that the Police (who had seen the two ladies) had indicated that the Ambulance Service should still attend.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 13th August 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 Person namely [redacted]**, Executor of Margaret's estate**. I have also sent it to **Chief Constable of Sussex Police** who may find it useful or of interest. 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	**25th June 2018**  **Penelope Schofield, Senior Coroner**