	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. East Midlands Ambulance Service** **2. 111 Service**
1	**CORONER** I am Mr Hassan Shah, Assistant Coroner for the coroner area of Northampton.
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 06/06/2018 I commenced an investigation into the death of Diana Faith Gudgeon. The investigation concluded at the end of an inquest on 13/12/2018. The narrative conclusion of the inquest is set out below in section (4). The medical cause of death was:- 1a) Multi organ failure 1b) Gram negative septicaemia 1c) Urinary tract infection 2) Ulcerative colitis, Type 2 diabetes mellitus, chronic kidney disease
4	**CIRCUMSTANCES OF THE DEATH** Mrs Gudgeon was diagnosed on 21st May 2018 by her GP with a water infection; she also had a history of recurrent water infections. At some point after the call to her GP, Mrs Gudgeon had a collapse/fall in her bedroom at home as a result of which she remained lying on the floor for a prolonged time. On the 22nd May 2018 at 9.57pm, a call was passed from 111 to the East Midlands Ambulance Service (EMAS) Emergency Operations Centre. Mrs Gudgeon had signs of central nervous system and neurological problems which required an urgent response but instead the call was given a category three 120-minute response. A nurse telephoned Mrs Gudgeon at 11.42pm and undertook a further triage during which the nurse was told that Mrs Gudgeon may be suffering from a urinary tract infection. No escalation occurred.

	A solo responder arrived on the scene at 4.50am on 23rd May 2018, around 7 hours after the first notification. No treatment was commenced at that stage, save oxygen was given. Observations were taken but not actioned. A double crewed ambulance arrived at 6.28am, around 8.5 hours after the initial call. It was then determined that Mrs Gudgeon's abnormal vital signs were possibly due to infection and sepsis. Mrs Gudgeon arrived at Northampton General Hospital at 7.10am where despite full and active treatment in the High Dependency Unit, Mrs Gudgeon died on 25th May 2018. The Consultant in Intensive Care & Anaesthesia states "if antibiotics were given earlier, then the severity of multi organ failure that occurs in septic shock may have been less. Current evidence shows that Mrs Gudgeon would have benefited from prompt treatment; this may have prevented her death". EMAS state that the Northampton division was 6 double crewed ambulances and 4 fast response vehicles short on the shift and this had a "significant impact on service". Although EMAS was in a Capacity Management Plan (CMP) status (initially 2 and escalated to 3 at 10.35pm on 21st May 2018) this did not lead to the deployment of any additional vehicular resource. EMAS say that additional financial resources have now been made available.
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. Triaging by '111' and EMAS call handling systems, including in relation to sepsis. In the present case, Mrs Gudgeon had collapsed, passed out, been confused and had been vomiting. These are signs of central nervous system/neurological problems but were not regarded as urgent. Despite EMAS being told that Mrs Gudgeon may have a urinary tract infection, no escalation occurred. 2. It was suggested in evidence that if the same facts are inputted into the '999' AMPDS triaging system they are likely to allocate a higher priority to the call than the '111' Pathway triaging system would. 3. The shortage of double crewed ambulances and fast response vehicles in the Northampton Division. 4. The effectiveness of the EMAS Capacity Management & Escalation Plan (CMP) including, inter alia, the fact that:- a) CMP status 1 – 3 does not trigger the deployment of additional

	vehicular resources. b) CMP 4 is only triggered when 200 calls are holding (this was previously 150) – this is a high threshold. c) A Technical Commander can overrule a CMP status e.g. even if 200 calls are holding (CMP 4), this can simply be downgraded to CMP 3 by the Technical Commander.
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 **Friday 8th March 2019**. 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] **(son).** Similarly, you are 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.
9	*H Shah* – ***Mr H Shah – Assistant Coroner*** **9th January 2019**