HM SENIOR CORONER
Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. United Lincolnshire Hospitals NHS Trust
1.	**CORONER** I am Paul Duncan Smith, Area Coroner for the Coroner Area of Lincolnshire, 4 Lindum Road Lincoln LN2 1NN
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 7 February 2018 I commenced an investigation into the death of Gail Bailey (dob 03.07.81). The investigation concluded at the end of the inquest on 18 November 2018. The inquest returned a narrative conclusion in relation to Mrs Bailey's death, the medical cause of death being: 1a. Haemoperitoneum 1b. Ruptured ectopic pregnancy of the left fallopian tube.
4.	**CIRCUMSTANCES OF THE DEATH** 1. On 5 August 2017 Mrs Bailey was on holiday with her family in a caravan at Promenade Caravan Park Ingoldmelds. She was known to be 9 weeks pregnant. 2. During the afternoon she began to experience abdominal discomfort. The telephoned the Early Pregnancy Unit at her home hospital in Rotherham. She was advised to seek a scan at a local hospital. 3. An ambulance was called at 17.02 hours but due to delays by EMAS did not arrive until 19.40 hours. Mrs Bailey was taken to Boston Pilgrim Hospital at 20.16 hours and arrived at 20.51 hours. She was declared deceased at 21.40 hours.
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. – A) I received evidence that on the facts of this case, the latest time that Mrs Bailey could have arrived at hospital with any realistic prospect of survival was 19.40 hours. Ultimately the decision to take her to Boston Pilgrim hospital was futile, although that was not known at the time. B) I also received evidence that two pre-alert calls were made by the travelling paramedics to Boston Pilgrim Hospital to advise of the serious nature of Mrs Bailey's condition, those calls being made at approximately 20.30 hours and at 20.42 hours.

	C) I received evidence from Mr Bailey that upon arrival at hospital the clinicians appeared not to be ready for his wife's arrival. D) I received evidence from Mr [redacted], consultant in the Accident and Emergency Unit at Boston Pilgrim Hospital, that [redacted], a Specialty Doctor in Emergency medicine present at the time had noted in the medical records that he, together with other doctors had attempted to resuscitate Mrs Bailey who had presented to A & E in a collapsed state around 21.00 hours and had noted that " a cardiac arrest call-out had also been initiated in or around the time of the patient's arrival to Pilgrim." E) I received evidence from the locum registrar for the labour ward, [redacted] that "[My understanding at that time was that] no Obstetrician and gynaecologist was forewarned about this patients arrival to the A & E department." F) The ED records confirmed that two pre alert calls were recorded but not dated nor signed. G) Whilst the severity of Mrs Bailey's condition meant that in the particular circumstances of this case the treatment Mrs Bailey received at hospital neither caused nor contributed to her death, the apparent breakdown in communication does raise an area of concern in relation to future emergency admissions.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation has 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 29 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 1. [redacted] 2. EMAS 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.
	Dated this 23rd January 2019 day of January 2019 **…….** **P D Smith** **Area Coroner**