Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
Mr Richard Alsop, Chief Operating Officer, Milton Keynes CCG

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of 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.

3 INVESTIGATION and INQUEST

On 23/08/2018 I commenced an investigation into the death of Douglas Albert Walter MINNS aged 93. The investigation concluded at the end of the inquest on 17th December 2018. The conclusion of the inquest was that the deceased died from an accident, namely the fall at home.

4 CIRCUMSTANCES OF THE DEATH

The deceased suffered a fall at home, [redacted], on 21st August 2018 at 8.30pm in the evening and he made an emergency call to the ambulance service. He was attended to by the ambulance service at 00.25 on 22nd August 2018 and he was eventually conveyed to Milton Keynes University Hospital arriving at 02.08. A CT scan revealed a large subarachnoid and subdural bleed caused by the fall. He died at the hospital at 15.50 on 22nd August 2018. The delay in the ambulance attending was due to high operational demand.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: During the course of the evidence it was explained to me that the provision of a falls service was withdrawn some years ago, the service would provide for someone to attend the home of the person who had fallen, get them on their feet, assess their wellbeing, serve a cup of tea and get them back into bed if required. If they required more urgent treatment, they would report to the ambulance service. The withdrawal of the service puts patient's lives at risk and, in view of the strains on the ambulance service, consideration should be given to re-introducing it. It is unacceptable for a 93 year old man to be left lying on the floor for four hours before someone responds.

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 4th April 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

South Central Ambulance Service
The Family of Mr Minns

I have also sent it to the Chief Executive of Milton Keynes Hospital 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

Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 14 February 2019