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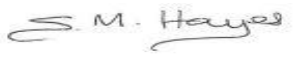
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive of South East Coast Ambulance Service** **2. The Chief Executive of East Kent University Hospitals** **3. The Chief Executive of NHS England**
1	**CORONER** I am Sonia Hayes Assistant Coroner for **North East Kent**
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 29th December 2017 an investigation was commenced into the death of Mildred CLARK. The investigation concluded at the end of the inquest 7th March 2019. The conclusion of the inquest was Died at 15:10 on 17th December 2017 at hospital following infection and failure of bypass graft to provide blood supply to the leg and haemorrhage that was incompatible with life. Delay in diagnosing the infection and haematoma on 16th December meant medical intervention options were limited. Conclusion Narrative 1a **Bilateral Acute Lower Limb Ischaemia** b **Occluded Femoral Bypass Graft** c **Haemorrhage from Infected Graft Left Groin** II **Ischaemic Heart Disease**
4	**CIRCUMSTANCES OF THE DEATH** Patient presented with a mass in the groin and ambulance called. Eventually diagnosed following significant delay at William Harvey Hospital as failure of previous bypass surgery grafts. She was transferred by Kent & Canterbury surgery was performed and despite being able to stop the bleeding, it was not possible to restore blood flow to the leg because of infection in the graft and delay in treating the ischemia. There was significant delay in recognising the bleeding due to the failed bypass grafts and resulting ischemic limb meaning options for medical intervention were limited. The only option was palliative. Previous surgery- aortic femoral bypass for aneurysm. Bypass for ischaemic right leg had been performed, most recently in August this year. Unfortunately, on this occasion it was not possible to re-vascularise the legs which were already ischaemic beyond repair (on the right) and made ischaemic by arterial ligation (on the left) to control the bleeding.
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. – Although this matter did not contribute to this death a concern was raised that a paramedic sought telephone advice from a hospital doctor by telephone on presenting symptoms and the initial diagnosis was that of a hernia there was extreme pain. The paramedic was instructed to carry out a procedure to reduce the hernia despite being informed that the paramedic was not trained to do so. The attempt caused extreme pain and failed. (1) A senior member of ambulance crew gave evidence that reducing a hernia was not the role of a paramedic and a doctor should not instruct a paramedic to carry out this procedure particularly when they have stated they are not trained. (2) A consultant surgeon gave evidence that: a. a suspected hernia is not a medical emergency and there was no pressing requirement to undertake the procedure that could lead to complications if incorrectly carried out b. where there is pain, swelling and hardness as in this case, if a hernia is suspected it would be reasonable to consider if this was a case of strangulated hernia as this could be a medical emergency and an attempt to reduce it cause significant complications and a patient should be taken to hospital (3) There was a concern raised that staff may have felt pressured to act to avoid hospital admission during a period of winter pressure

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 8th July 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] (family),CEO South East Coast Ambulance Service, CEO East Kent University Hospitals. I have also sent it to the Simon Stevens, Chief Executive of NHS England 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	15th May 2019 Signature:  Sonia Hayes Assistant Coroner **North East Kent**