	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Anthony C Marsh, Chief Executive West Midlands Ambulance Service
1	**CORONER** I am James Bennett Area Coroner for Birmingham and Solihull.
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 02/08/2019 I commenced an investigation into the death of Emma Jayne Langley. The investigation concluded at the end of an inquest on 30th October 2019. The conclusion of the inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** On 30 April 2019 Emma was diagnosed by her GP with an ear infection. On 1 May she was at home and developed a headache and vomiting and her family telephoned the 111 service, which resulted in an ambulance attending at 16.22. A paramedic considered the ear infection as the likely source of the symptoms. Meningitis was not considered. Two sets of observations were undertaken alerting the paramedic that the NEWS2 scoring system required Emma to be taken to hospital. A third opportunity to take observations was missed. The Sepsis Tool was not used - had it been used, it would have raised an amber warning alerting the paramedic that Emma needed to be taken to hospital. The paramedic wanted Emma to go to hospital but did not fully convey the clinical findings in order that Emma and her family could make an informed decision. No Discharge Form was provided to Emma and her family. The WMAS Electronic Patient Record was summarised to Emma's partner and he signed the 'non-conveyance' statement. He did not realise they were rejecting a recommendation that Emma needed to go to hospital. The ambulance left at approximately 18.09, having arranged for a Dr via the 111 service to telephone Emma. At approximately 21.26 Emma was found collapsed in bed by her family, who called 999 and commenced CPR. Paramedics arrived at 21.34 and commenced advanced life-saving treatment without success, and Emma was confirmed deceased at 22.02. Post-mortem tests revealed that Emma had developed Streptococcus pneumoniae which is recognised as having a very rapid progression rate. It is difficult to predict precisely how Emma would have responded to treatment had she been taken to hospital at approximately 18.00hrs, but it is unlikely treatment would have changed the outcome. The medical cause of death was determined to be:- 1a. acute meningitis 2. diabetes mellitus.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. The deceased/her family were keen for her to be admitted to hospital. The paramedic asked the deceased's partner to sign the 'non-conveyance' statement on his EPR tablet after summarising a 1 hour 45 minute attendance. The rejection of medical advice was diluted by other details. The deceased's partner stated he did not appreciate what he was signing. He was distressed and emotional and the room had been busy with family members, the paramedics and his ill partner. In my judgment, the facts of this case demonstrate the current system of signing a screen on a tablet after a generic summary, does not adequately amplify to a patient/their family (who might be distressed and emotional) they are rejecting medical advice to be admitted to hospital. 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.

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 13/01/20. 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 the family. I have also sent it to 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	18/11/2019 Signature  James Bennett Area Coroner Birmingham and Solihull