REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. West Midlands Ambulance Service**
1	**CORONER** I am Joanne Lees, Area Coroner for the coroner area of the Black Country Jurisdiction
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 30/9/20 I commenced an investigation into the death of Elsie Yvonne Taylor dob 14/2/52. The investigation concluded at the end of the inquest on 7/12/20. The conclusion of the inquest was a short form conclusion of accident. The medical cause for the death was established at post mortem as; 1a) Pneumothorax 1b) Rib Fractures 1c) Fall 2) COPD and IHD
4	**CIRCUMSTANCES OF THE DEATH** (1). The deceased was a 68-year-old lady who had a past medical history of chronic obstructive pulmonary disease, atrial fibrillation on anti-coagulation and ischaemic heart disease with stents. (2) On 15/9/20 she suffered a fall at her home address whereby she fell into a rose bush landing on her left-hand side. The fall was witnessed by a neighbour who helped her up. An ambulance was called approximately 1.5 hours later. (3) Paramedics attended and recorded left sided pain and bruising. There was no loss of consciousness and she was advised to take painkillers, was referred to her GP (with a discharge notice left) and verbally informed to contact emergency services if the pain or her breathing should worsen. (4) A further ambulance was called some 4 hours later where the deceased reported worsening pain and some difficulties breathing. A facial swelling was also noted with suspected allergic reaction. (5) She was taken to hospital where she had a chest drain inserted and was presenting as peri arrest. A cardiac cause was ruled out but sadly she deteriorated and passed away later the same day. (6) A post mortem revealed a pneumothorax and rib fractures consistent with a fall.

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) The attending paramedic gave evidence at the inquest that on 15/9/20 the deceased had declined a hospital admission against advice due to concerns about Covid-19. This was not recorded in the EPR and the first time the family became aware of this was when a statement was received from the paramedic 2 days before inquest; (2) The EPR did not record that the deceased had been advised to go to hospital nor that she understood any such advice and she was not asked to sign a disclaimer; (3) There was no information left by the attending paramedic crew to reflect the decision of the deceased to decline admission or the advice given by paramedics. The family of the deceased were not present during the consultation and as a consequence they did not know what symptoms to look out for which might suggestion a deterioration in the condition of the deceased; (4) There was no note left by the attending paramedic crew detailing the outcome of the consultation; (5) the discharge notice left by paramedics contained her observations only and the wording suggested she had been referred to her GP as an alternative to a hospital admission; (6) The deceased lived alone and suffered with COPD and IHD. No attempt was made to contact the GP of the deceased or a family member despite the fact it was known that the deceased lived alone (it was noted in the EPR).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 8/2/21. 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], daughter of the deceased and the CQC. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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	**14/12/20**  Joanne Lees Area Coroner