Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Premier Rescue Ambulance Services
Unit 17 Corlish Way
East Galmington Trading Estate
Taunton
TA1 5LZ

1. CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

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

On 08/01/2020 I commenced an investigation into the death of Peggy Joan COPEMAN aged 81. The inquest has not yet been heard

4. CIRCUMSTANCES OF THE DEATH

Mrs Peggy Copeman was placed under s 2 MHA on 10.12.2019 and was taken to Cygnet Hospital, Taunton on 12.12.2020. She was being transported back to Norfolk on 16.12.2019 by Premier Rescue Ambulance Service (PRAS). PRAS transfers patients to or from a healthcare facility or other such location, providing care during transit. During the journey Mrs Copeman had altered breathing. When driving along the M11 a short distance prior to junction 9, Mrs Copeman was noted to have mucous coming from her nose and the ambulance pulled over on the hard shoulder. Mrs Copeman was noted to be unresponsive. Telephone calls were made to Cygnet House and PRAS and then emergency services were called. Mrs Copeman was declared dead at the scene.

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. PRAS Conveyance Policy provides that staff escorting patients "*are to be fully trained in Basic Life Support (BLS) and are deemed to be competent to apply the techniques when needed. Staff can notice any changes or deteriorating patients and act appropriately in line with BLS training. Starting with Primary assessments followed by secondary assessment then commencing CardioPulmonary Resuscitation (CPR) while waiting for ambulance to arrive* … "
2. The evidence so far is that during transit, Peggy did not respond when being called or when moving her head and on being noted as being unresponsive, emergency services were not called immediately but calls were initially made to Cygnet and then PRAS. CPR was started on being told to do so by emergency services
3. On attendance by Paramedics it was noted that due to the position of the patient in the back of the van, CPR was ineffective
4. A report has been obtained from a Consultant Cardiologist and General Physician as an expert witness who is of the firm view that the staff transporting Mrs Copeman did not recognise she was in respiratory distress and/or cardiac arrest and that she had effectively died whilst sat between them
5. Only one member of staff out of three had training in CPR
6. An internal investigation (undated) carried out shortly after the incident did not raise concern about these matters
7. A statement provided by the Compliance Manager, PRAS, dated 7 May 2021 concludes that

"the ambulance was adequately staffed to enable the journey to be safely carried out", despite only one member of staff being trained in CPR contrary to PRAS's own Conveyance Policy

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe 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 20 July 2021. 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:

a) [redacted] (daughter) and [redacted] (husband)
b) Cygnet Healthcare
c) Norfolk and Suffolk NHS Foundation Trust
d) Care Quality Commission
e) [redacted]

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. Dated: 28 May 2021

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN