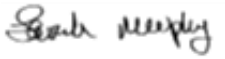
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive Royal Stoke University Hospital** **Chief Executive NHS England**
1	**CORONER** I am Sarah Murphy HM Assistant Coroner for **Stoke-on-Trent & North Staffordshire Coroner's Court**
2	**CORONER'S LEGAL POWERS** 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 02/08/2021 I commenced an investigation into the death of Shaun Mansell, aged 50. The investigation concluded at the end of the inquest on 1st November 2021. The conclusion of the inquest was Shaun Mansell died of natural causes. Sean Mansell had a medical history of alcohol dependence syndrome. On the 5th July 2021, the West Midlands Ambulance Service received a 999 call at 19.23 hours from a neighbour of the deceased who reported that the deceased couldn't walk. The call was allocated a category 3 disposition which had a target response time frame of 120 minutes. An ambulance arrived on scene at 03.38 on the 6th July which was 8 hours and 15 minutes later and not within the response time frame. This was due to the fact that demand outstripped available resources. A welfare call was undertaken at 21.28 hours by a paramedic who had been asked to go into the control room to assist with welfare calls due to the high volume of 999 calls outstanding. The paramedic had not received prior training on how to complete these calls. The welfare call was conducted with the neighbour. No contact was made directly with the deceased during the 8 hour delay which led to a missed opportunity to identify a change in his condition. When the ambulance arrived, the deceased had passed away on the sofa in his front room. There was evidence of blood loss on the floor next to the deceased and around his mouth. The police did not find any suspicious circumstances. A post mortem examination found the cause of death to be acute gastrointestinal haemorrhage and liver disease due to chronic alcoholism. The medical evidence was not able to determine if the delay in the arrival of the ambulance contributed to the death because there was no certainty of timeline about the bleeding. . - -
4	**CIRCUMSTANCES OF THE DEATH** See above
5	**<u>CORONER'S CONCERNS</u>** 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. – [BRIEF SUMMARY OF MATTERS OF CONCERN]

	(1) There were excessive delays in handing over patients at hospital. The West Midlands Ambulance Service Serious Incident report found that there were excessive handover of patients at the Royal Stoke University Hospital, with some holding for over 4 hours. This impacted on the ability of the West Midlands Ambulance Service getting to patients. Oral evidence was given to the effect that this was a national issue, and not limited to the acute trusts within the West Midlands.
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 12th January 2022. 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. I am also under a duty to send the Chief Coroner a copy of your response 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	01/11/2021 Signature___  _____ Sarah Murphy HM Assistant Coroner **Stoke-on-Trent & North Staffordshire Coroner's Court**