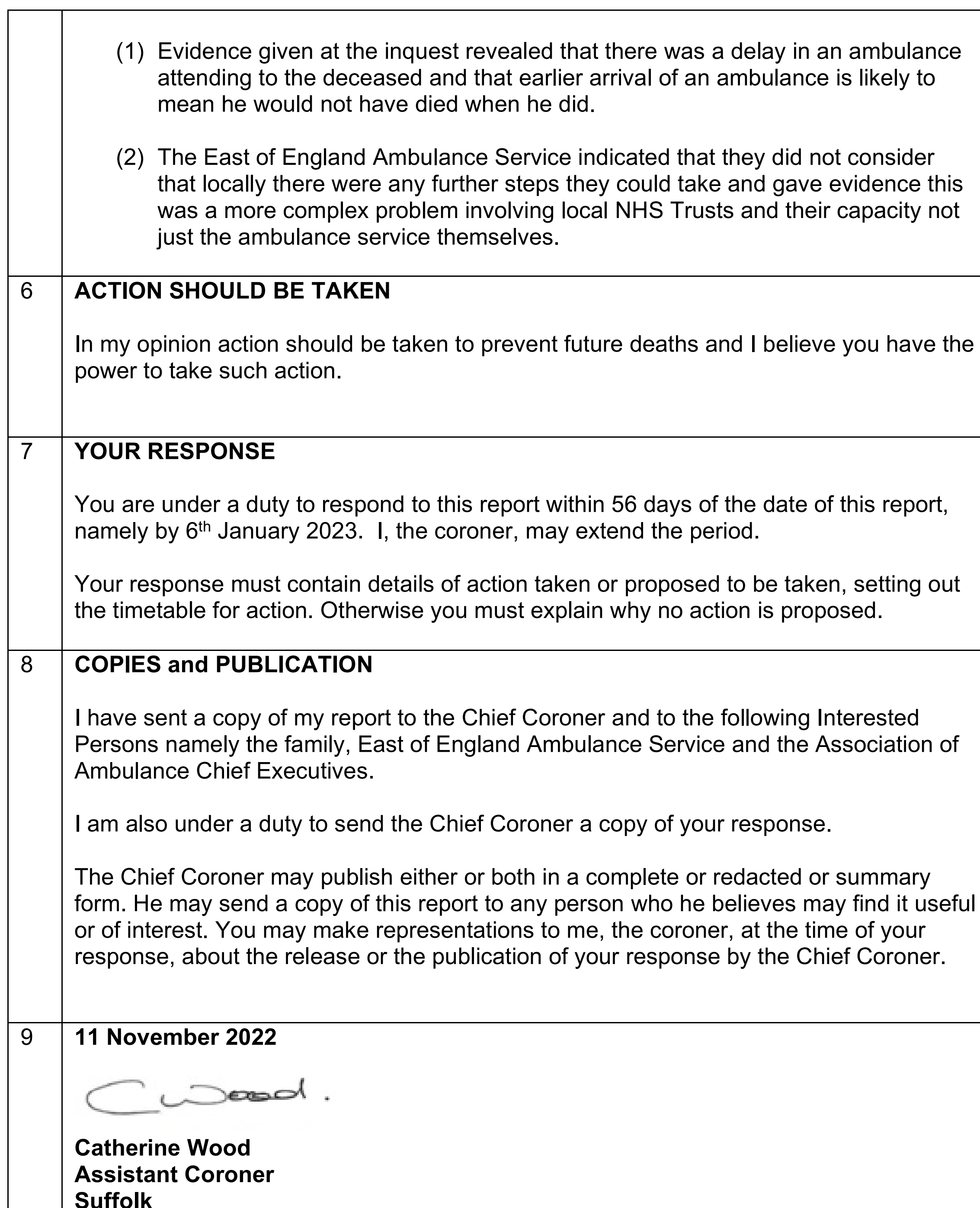
REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Secretary of State for Health and Social Care** 2. **The Department of Health and Social Care**
1	**CORONER** I am Catherine Wood, assistant coroner, for the coroner area of Suffolk.
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 the 25th May 2022 an inquest was opened into the death of Derek Shaw. At the inquest hearing on 11th November 2022 I concluded with a narrative conclusion "He died as a consequence of a soft tissue haemorrhage into his anterior abdominal wall following a fall, contributed to be a delay in an ambulance being available to attend to him."
4	**CIRCUMSTANCES OF THE DEATH** (1) Derek Shaw fell at home on the 21st December and the following morning became unwell. He called an ambulance at 12.52 and the ambulance call was classified as a category 3 call meaning the target time to reach him was 120 minutes. (2) Capacity meant that no ambulance could be dispatched and whilst one was initially dispatched at 15.46 this ambulance was diverted to a higher priority call. He deteriorated and the ambulance service were contacted again and the category of his call upgraded at 16.46 when he was still conscious. (3) By the time the ambulance crew arrived at 17.12, he had suffered a cardiac arrest and attempts at resuscitation were unsuccessful. (4) A post mortem examination revealed that he had died as a consequence of a soft tissue haemorrhage into his anterior abdominal wall as a consequence of the fall. The Pathologist gave evidence that this was an unusual cause of death and earlier intervention would have meant it likely Mr. Shaw would have survived. (5) The East of England Ambulance Service indicated that they did not consider that locally there were any further steps could be taken by them to Prevent Future Deaths as they had already put steps in place in so far as they were able.
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) Evidence given at the inquest revealed that there was a delay in an ambulance attending to the deceased and that earlier arrival of an ambulance is likely to mean he would not have died when he did. (2) The East of England Ambulance Service indicated that they did not consider that locally there were any further steps they could take and gave evidence this was a more complex problem involving local NHS Trusts and their capacity not just the ambulance service themselves.
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 6th January 2023. 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 namely the family, East of England Ambulance Service and the Association of Ambulance Chief Executives. 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	**11 November 2022** **Catherine Wood** **Assistant Coroner** **Suffolk**