REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28: REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** International Academies of Emergency Dispatch 110 Regent St #800 Salt Lake City UT 84111 United States
1	**CORONER** Tanyka Rawden, Senior Coroner for South Yorkshire (West)
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 16 February 2022 an investigation commenced into the death of Roy Middleton, aged 85 years. The investigation concluded with an inquest heard on 16 November 2022. The Coroner returned a narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** On 9 February 2022 Roy Middleton fell at his home address in Sheffield and struck his head. A carer requested emergency medical assistance at 16:41 advising the Yorkshire Ambulance Service that he was taking warfarin; he had a large cut to his head and there was 'quite a lot' of bleeding. The call was allocated a category 3 response time with a 90% centile target of 2 hours. A second call was made to the Yorkshire Ambulance Service by a carer at 19:52 requesting an update on the arrival of an ambulance and expressing concern Mr Middleton was concussed. The call was allocated a category 3 response time. At 20:30 a paramedic from the clinical hub at Yorkshire Ambulance Service called and spoke to Mr Middleton's son who described a 4-inch laceration to the back of Mr Middleton's head and that Mr Middleton was becoming impatient and worried. He was also concerned about the amount of blood and stated his father was frail and concussed. The call was allocated a category 3 response time. This assessment was not performed correctly, and the call should have been changed to a category 2 which would have resulted in an ambulance would have arrived sooner.

	At 22:04 a call was made by Mr Middleton's son to Yorkshire Ambulance Service requesting an update on the arrival of an ambulance and stating his father's condition had not changed. A resource was allocated at 22:33 and arrived on scene at 22:47, 6 hours and 6 minutes after the initial call. Mr Middleton was taken to the Northern General Hospital in Sheffield where he was diagnosed with a traumatic acute subdural haemorrhage which was not fit for medical intervention. He died in hospital on 10 Feb 2022 as a result of this injury. The medical cause of death found was: 1a. Traumatic acute subdural haemorrhage 2. Atrial fibrillation, tricuspid valve replacement (anticoagulated), Type II diabetes mellitus, ischaemic heart disease and chronic obstructive pulmonary disease The narrative conclusion given was as follows: Roy Middleton fell at his home address on 9 February 2022. Emergency medical assistance was requested but did not arrive until six hours and six minutes after the request was made due to service demands and a missed opportunity to re-categorise the call. Mr Middleton was admitted to the Northern General Hospital where he was diagnosed with a traumatic acute subdural haemorrhage. He died in hospital on 10 February 2022 as a result of this injury. Had he presented at hospital sooner it is possible he could have been treated but it cannot be said whether he would have survived.
5	**<u>CORONER'S CONCERN</u>** During the course of the investigation my inquiries 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 **MATTER OF CONCERN** is as follows:- The inquest heard that the International Academies of Emergency Dispatch system algorithm does not take into account whether a patient is on blood thinning medication when considering the category of emergency response required. The inquest also heard from a consultant geriatrician that "by the time he arrived at the hospital he was not fit for any intervention". I am concerned that if the algorithm isn't changed to take into account the affect of anti-coagulant medication on a head injury, deaths will occur in the future. I am aware the Yorkshire Ambulance Service have raised the same concern with the International Academies of Emergency Dispatch as a result of this incident.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 12 January 2023. I may extend this period upon your application. 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: The family of Mr Middleton Yorkshire Ambulance Service I have also sent a copy of my report to the Secretary of State for Health 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	**17th November 2022**  Mrs Tanyka Rawden **HM Senior Coroner**