Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Will Quince M.P. Minister of state for Health.**
1	**CORONER** I am Tom OSBORNE, Senior Coroner for the coroner area of Milton Keynes
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 07 October 2022 I commenced an investigation into the death of Rita Maureen TAYLOR aged 84. The investigation concluded at the end of the inquest on 17 January 2023. The conclusion of the inquest was that: The deceased suffered an unwitnessed fall at her home, 43 Dodkin, Beanhill, Milton Keynes and suffered a head injury. An ambulance was called at 10.28 but due to lack of resources did not arrive until 17.17. When she arrived at Milton Keynes University Hospital at 17.58 her Glasgow Comma Score was 3. A CT scan revealed a large intracerebral bleed. She died the same day at the hospital. The delays in sending an ambulance resulted in a number of lost opportunities to admit her to hospital and begin her treatment.
4	**CIRCUMSTANCES OF THE DEATH** As outlined above and in Coroner's concerns
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) I am concerned that there are insufficient ambulance service resources to meet the needs of the City of Milton Keynes. The first call to the 111 service was made at 10.28 and the call was deemed a category 3 incident. |At that time there were "no available resources to send." At 11.12 a 999 call was made by a passer by but there were still "no available resources ". At 12.16 there was a further 999 call. The incident remained a category three and was "still pending in the dispatch queue waiting for resources to become available ". At 12.41 a call was made to Mrs. Taylor's location but there were " still no available resources to send" At 13.12 A further 999 call was made " awaiting resources to become available" At 13.48 Patient location was called she was now in and out of consciousness and although she remained a category 3 an audit of the call decided that she should have been upgraded to a category 2 or 1. "Still no available resources".

	At 14.42 further 999 call but again "no available resources". At 15.25 Case reviewed to a category 2. At 16.29 An ambulance was despatched arriving at 17.15. This was 6hours 47 minutes after the original call and 1hour 49 minutes after category 2 upgrade. Mrs Taylor arrived at the hospital at 17.57 and when assessed in the emergency department her Glasgow Comma score was recorded as 3.She died later the same day.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 March 20, 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 **South Central Ambulance Service** I have also sent it to **MK Together** who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 25/01/2023**  **Tom OSBORNE** **Senior Coroner for** **Milton Keynes**