REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. International Academics of Emergency Dispatch, Suite B, 4th floor, Spectrum, Bond Street, Bristol BS1 3LG**
1	**CORONER** I am Brendan Joseph Allen, Area Coroner, for the Coroner Area of Dorset
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 5th November 2021, an investigation was commenced into the death of Kenneth Michael Adams, born on the 21st August 1951. The investigation concluded at the end of the Inquest on the 9th March 2023. The Medical Cause of Death was: 1a Hypoxic brain damage 1b Cardiac arrest 1c Profuse bleeding from a laceration of the scalp 2 Treatment with clopidogrel for stenosing atherosclerosis of carotid arteries The conclusion of the Inquest recorded that Kenneth Michael Adams died as a consequence of an accident to which a failure to provide emergency medical assistance in a timely manner more than minimally contributed. A failure of the Medical Priority Despatch System to acknowledge and assess persistent bleeding from a scalp injury against a background of antiplatelet medication also possibly contributed to his death.

4	**CIRCUMSTANCES OF THE DEATH** At approximately 3.30am on 19th October 2021, Kenneth Michael Adams, who was prescribed clopidogrel and who lived alone at 60 Vernons Court in Bridport, which is supported housing provided by a housing association, suffered an accidental fall from a standing height, which resulted in a laceration to his scalp. At 4.06 am Mr Adams contacted the ambulance service to explain that he had fallen, injured his scalp and that he could not stop the bleeding. Mr Adams' call was triaged using the Medical Priority Despatch System, which resulted in a disposition of 17-b-01: fall possible dangerous area. This translated to a category 3 ambulance response. The national target set by the Department of Health is to attend category 3 incidents within 120 minutes on at least 90% of occasions (so by 6.13 am), with an average response time of 60 minutes (by 5.13am). At the time of this call, Mr Adams appeared well with no additional symptoms. Mr Adams had also activated his careline, which is an element of the support provided by the housing association. At 7.53 an operator from the careline contacted Mr Adams to check on his welfare. Mr Adams reported that he was now feeling sick, that he was wobbly when stood up and that his bleeding was continuing. The careline operator contacted the ambulance service and advised of the new symptoms. A further triage was conducted, with the same disposition of fall, possibly dangerous area being reached, as the algorithm being used failed to account for the persistent nature of the bleeding being experienced and that Mr Adams was prescribed clopidogrel. At 10.25 Mr Adams again spoke to a careline operator. He was by now slurring his words and his speech was noticeably slow. It is likely he was experiencing symptoms associated with hypovolaemic shock. If Mr Adams had received treatment by 10.25, he would have survived the injury he had sustained. The first ambulance resource arrived at Mr Adams' property at 11.56, by which time a neighbour had found Mr Adams when Mr Adams had called for his help. Mr Adams was conveyed to Dorset County Hospital, where despite treatment he died on 19th October 2021.

5	**CORONER'S CONCERNS**

The **MATTERS OF CONCERN** are as follows:

1. During the inquest evidence was heard that:

    i. A patient, prescribed either antiplatelet or anticoagulant medication, falling and sustaining a scalp laceration that is not "spurting or pouring blood" (the MPDS definition of "uncontrolled bleeding"), will never reach an MPDS disposition that results in a prioritisation higher than category 3, regardless of how long the bleeding has been persisting, unless the patient becomes unconscious or stops breathing. I heard evidence that the scalp is an area of high venous blood flow, such that a laceration to the scalp is capable of bleeding significantly. However, because of the nature of the blood supply in this area, the wound will not "spurt or pour" blood, so with the current iteration of MPDS a wound in this area of the body can never be considered as "serious haemorrhage". Despite this, when assessing the seriousness of a bleed that does not meet the criteria for a "serious haemorrhage", the MPDS algorithm does not allow for consideration of any delay in treatment or for the consideration of medications that may either exacerbate the extent of a bleed or prevent the blood from clotting to stop the bleed. For a patient such as Mr Adams, prescribed antiplatelet medication, there is a considerable risk that the bleeding will persist until the wound is closed, such that a delay in receiving treatment, where the wound continues to bleed, leaves the patient at risk of developing hypovolaemic shock.

	2. I have concerns with regard to the following: i. Where a patient on anticoagulant or antiplatelet therapy sustains a fall and scalp laceration, the questions forming the MPDS protocol designed to assess the seriousness of the bleed and the prioritisation of an ambulance resource do not allow for consideration of the period of the time the bleeding has persisted from an area of high vascular blood flow or the medication prescribed. Therefore, in circumstances where the bleeding has persisted for a considerable time and where there is no evidence of the bleeding stopping, it seems the MPDS disposition reached would always be 17-b-01, with a consequent category 3 priority, which does not account for the increasing seriousness of the patient's predicament and the potential consequences of the continued blood loss.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 17th May 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: (1) Prince Evans Solicitors (solicitors for [redacted] brother of Mr Kenneth Adams); (2) Browne Jacobson Solicitors (solicitors for South Western Ambulance Service NHS Foundation Trust); (3) Appello Limited 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	**Dated** 22nd March 2023	**Signed**  **Brendan J Allen**