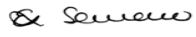
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England; and** **2. West Midlands Ambulance Service**
1	**CORONER** I am Emma Serrano, Assistant Coroner, for the coroner area of the South Staffordshire.
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 9th October 2021, I commenced an investigation into the death of Ms Sandra Diane Finch. The investigation concluded at the end of the inquest on 3 May 2023. The conclusion of the inquest was a narrative conclusion of ketoacidosis due to insulin depravation contributed to by neglect. The cause of death was: 1a) Ketoacidosis 1b) Uncontrolled Type 1 Diabetes Mellitus 1c) Insulin depravation
4	**CIRCUMSTANCES OF THE DEATH** i) Sandra Diane Finch was 44 year old woman who had a history of Type 1 diabetes mellitus. She used an insulin pump to administer insulin and had done so since 2005. ii) She had recently had a dental procedure and was also recently prescribed antibiotics for an infection. It was accepted by clinicians that this can cause a Type 1 diabetic to need more insulin than they would normally need. iii) On the 3 December 2021, Sandra Diane Finches glucose levels start to rise. This is picked up by the pump that she used and this sounded regular alarms and gave correctional doses of insulin. iv) On the 4 December 2021 Sandra Diane Finch called the West Midlands Ambulance Service and told them she was feeling more sleepy, her glucose was high and she had been vomiting. The categorisation of this call was category 3. This meant she was a medical emergency and required an ambulance. However, before an ambulance could be dispatched a clinical review Was required by the CV team. v) The team was under staffed and had no time limit attached for an assessment. As such, an attempt for an assessment did not take place until 10 hours later. At 7:22 a call was made to Miss Finch. This was

	unanswered. The options available, at this stage, would have been to dispatch an ambulance, or to place the call back, back into the CV Teams work load. This was what happened. vi) At 12:47 on the 5 December 2023 the decision was made by the team to categorise the ambulance request as a category 2 and dispatch an ambulance. This arrived at Sandra Diane Finches address at 13:08 and she was found to have passed away as a result of ketoacidosis. vii) Clinical opinion disagreed that category three was the correct categorisation. It should be have been a category 2. Evidence was heard that the pathway had to be followed rigidly so a computer could decide the category, but accepted that a clinician listening to the answers may well have made a different decision and given the call a category 2 marking. viii) The view of clinicians was that had the ambulance been despatched within the accepted time limit for a category 3 ambulance, Sandra Diane Finch would not have died when she did.
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 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. – 1. That the pathways used by the service to categorise the level of ambulance and ridged and have no capacity for movement away from the path. This led to a type 1 diabetic patient, who was feeling sleepy and with deranged glucose levels, not being classed as a potentially serious situation requiring rapid intervention. Clinical opinion in agreement that this was, but the rigidly of the pathway meant it was categorised incorrectly. 2. That the use of an assessment team, to asses a category 3 ambulance call, with no time limit for assessments to take place, and no prioritisation system, will lead to further deaths resulting from delays.
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 27 June 2023. 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. West Midlands Ambulance Service; 2. NHS England;

	3. Medtronic Ltd; and 4. Family of Sandra Dianne Finch 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	**9 May 2023**  **Miss Emma Serrano** **Area Coroner** **Stoke on Trent and North Staffordshire**