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:** **The Secretary of State for Health and Social Care, The Rt Hon Steve Barclay MP** **And** **The Department of Health and Social Care**
1	**CORONER** I am Jacqueline Lake, Senior Coroner for the coroner area of Norfolk.
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 24 February 2023 I commenced an investigation into the death of John Trevor WINSWORTH aged 92. The investigation concluded at the end of the inquest on 25 September 2023. **The medical cause of death was:** 1a) Traumatic Intracranial Bleed 1b) Fall 1c) 2) Atrial Fibrillation (on Warfarin) **The conclusion of the inquest was:** Accident
4	**CIRCUMSTANCES OF THE DEATH** Mr Winsworth was found on the floor at his home on 14 February 2023. Emergency services were called at 11.55 hours. An ambulance arrived at 09.30 on 15 February 2023 and Mr Winsworth was taken to Norfolk and Norwich University Hospital, arriving at 10.52 hours. He was admitted to Accident and Emergency Department at 14.42 hours. A CT scan showed a small bleed in the brain and Mr Winsworth's Warfarin medication was stopped and he was given Vitamin K to promote clotting. Mr Winsworth was not referred to the Haematology Department in accordance with internal protocol, when it is probable medication to promote blood clotting within a shorter space of time would be prescribed. Mr Winsworth was assessed as fit to be discharged following examination and assessment. He was unable to get into a motor car and hospital transport was arranged. Mr Winsworth was returned to the ward. His condition suddenly deteriorated and he died on 21 February 2023 in hospital.
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: 1. The ambulance service was called at 11.55 hours on 14 February 2023 and the call was graded as a Category 3 call, requiring a response within 2 hours. The ambulance

	arrived at 09.30 hours on 15 February 2023. The time between calling the ambulance and the ambulance arriving on scene was in excess of 19 hours. 2. The ambulance arrived at the Norfolk and Norwich University Hospital at 10.52 hours and Mr Winsworth was not able to be admitted to Accident and Emergency Department until 14.42 hours; over 3 hours following admission, due to pressure on the hospital. 3. Considerable delays in attendance by EEAST (East of England Ambulance Service Trust) to calls continues.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** Your organisation is under a duty to respond to this report within 56 days of the date of this report, namely by November 24, 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: • [redacted] – son I have also sent it to: • East of England Ambulance Service Trust • Department of Health • Care Quality Commission • Healthwatch Norfolk • HSIB • NHS England and NHS Improvement 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: 29/09/2023** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH