# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

**REGULATION 28 REPORT TO PREVENT DEATHS**

**THIS REPORT IS BEING SENT TO:**
**The Chief Executive,**
**Yorkshire Ambulance Service (YAS)**
**Trust Headquarters**
**Brindley Way**
**Wakefield 41 Business Park**
**Wakefield**
**WF2 0XQ**

**The Chief Executive,**
**Association of Ambulance Chief Executives (AACE)**
**25 Farringdon Street**
**London**
**EC4A 4AB**

**1 CORONER**

I am the Assistant Coroner for the area of 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 and INQUEST**

On 12.12.22, I commenced an investigation into the death of Mark Bennett aged 38 The investigation concluded at the end of the inquest on 19.09.23 The conclusion of the inquest as to the medical cause of death was:

1a Pulmonary Embolism

1b Deep Vein Thrombosis

1c Immobility in relation to leg injury

I answered the statutory questions as follows:

Mark Bennett died on 14.04.22 at Meadowhall Shopping Centre Sheffield from a pulmonary embolism following a sprained ankle sustained in a trip on stairs in the London Underground on 05.04.22. There was a delay in the ambulance attending Mark caused by pressures on the ambulance service and an error in ambulance allocation.

I recorded a short form conclusion of accidental death

## 4 CIRCUMSTANCES OF THE DEATH

Mark tripped in the London underground on 05.04.22 causing damage to his ligaments in his right ankle. He was initially treated in the Royal Free Hospital, London and then had an outpatient appointment at his local hospital of Diana Princess of Wales Hospital in Grimsby, near to where he lived, on 11.04.22.

Mark collapsed with a suspected pulmonary embolism causing a cardiac arrest in the Meadowhall Shopping Centre Sheffield on 14.04.22.

During evidence of [redacted] for the Yorkshire Ambulance Service (YAS) in the inquest on 19.09.23, it emerged that paramedics attempted resuscitation of Mark for only 21 minutes. This was just within their then applicable protocol. Rather than transport Mark to the nearby accident and Emergency Department of the Northern General Hospital Sheffield, they declared ROLE and no further attempts a resuscitation took place.

Concern was expressed that this meant that there was no opportunity for thrombolysis to be attempted by hospital staff. [redacted] of YAS gave evidence that the guidance and protocols available for ambulance staff/paramedics on when to stop resuscitation and/or take to hospital for attempts at thrombolysis in these circumstances were unclear.

I was concerned that this lack of clarity on what constituted best practice on this issue for paramedics and/or ambulance staff might place future patients at risk in similar situations.

## 5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

5.1 I believe there is a lack of guidance and/or protocols on what constitutes best practice on this issue for paramedics and/or ambulance staff which might place future patients at risk in similar situations. In particular, how long should resuscitation continue for and when should a patient be taken to hospital for thrombolysis.

**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 15.10.23. 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 family of Mark Bennett (Interested Persons).

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.

**Steve Eccleston**
**Assistant Coroner for**
**South Yorkshire (West)**
**Dated: 19.09.23**