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 Yorkshire Ambulance Service**
1	**CORONER** I am Crispin OLIVER, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 21 March 2022 I commenced an investigation into the death of Peter STAJIC aged 60. The investigation concluded at the end of the inquest on 01 February 2024. The conclusion of the inquest was that: **He died from a complication following a medical procedure to which a missed opportunity to provide medical intervention contributed.**
4	**CIRCUMSTANCES OF THE DEATH** Peter was pronounced dead at 04.50 on 27 February 2022 at Calderdale Royal Hospital, Halifax. He was aged 60, fit and well save that he had required a carotid endarterectomy - undertaken on 12 January 2022. Due to a post operative haematoma, he was discharged on 16 January 2022. He developed an infection at the suture site. He was prescribed antibiotics by his GP. On 25 February he attended the Emergency Department at Calderdale Royal Hospital. This was an opportunity to discuss his case with a vascular consultant. It did not happen. On 26 February paramedics attended Peter at home at 10.42. There was evidence available of a herald bleed indicating that a major haemorrhage was likely to happen. This was not appreciated at the time and an opportunity was missed to admit Peter to the specialist Vascular Unit at the Bradford Royal Infirmary where, on the balance of probability, a procedure necessary to save his life could have been undertaken. In fact Peter was admitted to Calderdale Royal Hospital Emergency Department following a second attendance on his at home at 20.32 on 26 February. The concern at that stage was in relation sepsis, not the risk of haemorrhage. He was triaged to level 3. At 22.56 a nurse noted bleeding at the suture site. She reported this to a consultant of the Department, who was not equipped to appreciate its significance. Its is not available to conclude on a balance of probability that at that stage there would have been sufficient time to intervene to save Peter's life. Peter suffered a catastrophic haemorrhage shortly after 01.05 and consequently died.
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) Although detailed expertise concerning a herald bleed is specialist vascular knowledge that the paramedics who attended Peter at his home on the morning of 26 February 2022 would not be expected to possess, the evidence to the Inquest was that they would not have had any training in identifying one, nor any protocol for them to follow.
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 28, 2024. 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] I have also sent it to **Bradford Teaching Hospitals NHS Foundation Trust** **Calderdale Royal Hospital Mortuary** 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: 01/02/2024**  **Crispin OLIVER** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**