East Midlands Ambulance Service NHS Trust

Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham
NG8 6PY
Telephone: [redacted]
Fax: [redacted]
Website: www.emas.nhs.uk

Confidential

Ms L Costello
Assistant Coroner
1 Mount Tabor Street
Stockport
SK1 3AG

9 August 2024

Dear Ms Costello

Regulation 28 – Prevention of Future Deaths report regarding the case of Mr John Howe deceased

Thank you for your Regulation 28 report dated 25 June 2024, bringing to my attention HM Coroner's concerns arising from the inquest into the death of Mr John Howe.

I would like to assure you that the Trust takes all matters relating to patient safety extremely seriously. Matters arising from Coroner's Inquests, from which lessons can be learned, including Prevention of Future Deaths reports ,are discussed by the Trust's Incident Review Group.

Matters of Concern for East Midlands Ambulance Service Non-Emergency Patient Transport

The Inquest heard that there had been a change in policy with regards to the timing of discharge of patients from Manchester Royal Infirmary in circumstances where a patient is unable to manage independently when they arrive home. However, the Inquest heard that late discharges were still happening. In addition,

the Inquest heard that the East Midlands Ambulance Service (EMAS) were unaware of the change in discharge timings.

Sequence of events

Mr Howe was discharged from hospital on 19 May 2023, and he was woken from his sleep at 23:00 to be transported home from Manchester Royal Infirmary, meaning that he arrived at his home address in the early hours of the morning on 20 May 2023. Prior to the crew travelling, a call was made to the hospital to confirm that Mr Howe was still able to travel. The attending discharge crew did raise concerns on arrival at the ward around the appropriateness of Mr Howe going home at a late hour. I understand his family were not aware that he was being discharged and the access to his home was difficult. This resulted in Mr Howe being left outside whilst this was addressed.

Firstly, I would like to apologise that Mr Howe had an extended wait outside his address whilst arrangements were made to access his property.

During the Inquest, it was ascertained that discharges for patients on the wards at Manchester Royal Infirmary now have a cut off time at 21.00 hours for discharge from a hospital ward. At the time of the Inquest EMAS was not aware of this. EMAS has subsequently contacted Manchester Royal Infirmary for a copy of the new policy, but this is not available to share at present. From previous learning EMAS do already contact the ward when a patient is going to be discharged into the evening to ensure that this is appropriate, as happened with this case. This will continue as a safeguard to patients until the policy is received from Manchester Royal Infirmary.

I hope that this response provides you with the appropriate level of assurance in relation to our commitment to continuous improvement of our services.

Please do not hesitate to contact me should you require any additional information or any clarification, in connection with the above.

Yours sincerely

[redacted]

[redacted]

Deputy Chief Executive