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 NHS England & NHS Improvement (PFDs)** **2 Chief Coroner**
1	**CORONER** I am Kate ROBERTS, Assistant Coroner for the coroner area of Liverpool and Wirral
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 09 December 2022 I commenced an investigation into the death of Amanda Jane GAINFORD aged 52. The investigation concluded at the end of the inquest on 23 October 2024. The conclusion of the inquest was that: Amanda was a 52 year old lady detained under Section 2 Mental Health Act on 13/9/22 after a decline in her mental health. Amanda was initially on the Harrington ward before transfer to the Brunswick mental health ward at Broadoak hospital on 5/10/22. Amanda was in poor physical health and had underlying co-morbidities including liver cirrhosis caused by Hepatitis C and alcoholism which caused an enlarged spleen which made it more vulnerable to injury and trauma. Amanda mobilised using a Zimmer frame in part due to having a cast on her leg due to injuries sustained in a road traffic collision a number of years ago, the leg was pending amputation. During her time on both Harrington and Brunswick wards, Amanda was being assessed for a psychotic disorder secondary to polysubstance misuse. Her risks pertained to falls due to immobility, aggression and retaliation of others. During her time on Brunswick ward Amanda was subject to 1:1 level 4 observations at arms length and during her time on both Harrington and Brunswick wards, it was recorded that she had numerous unwitnessed and witness falls and documented incidents of physical aggression. On 24/10/22 Amanda came into conflict with another patient in the corridor in which a verbal altercation led to Amanda pushing the other patient and that patient pushing Amanda back. Amanda proceeded to pick up her Zimmer to her chest and move towards the other patient in which it inadvertently connected with the door fame and the top part of the Zimmer frame subsequently connected with Amanda's upper abdominal area with some force. She subsequently went towards the patient again, at which time the patient extended her leg to prevent Amanda coming closer which connected with her lower abdomen. Amanda thereafter engaged in deliberate actions of banging her head to the toilet wall and throwing herself to the floor in the bathroom and again in her bedroom reopening a cut to her head. Upon clinical assessment at around 5pm, observations were taken which detailed observations all in the normal range but for a low blood pressure. Advice was documented in the RIO notes but it was unclear as to the nature and extent of the advice given to health care staff supporting Amanda thereafter. It was clinically appropriate given Amanda's condition to give intravenous fluids and an ambulance should have been called, neither action was taken and there was a missed opportunity which may have possibly made her injuries survivable. Further blood pressure monitoring was recorded at around 8pm with no records of checks otherwise. Amanda's blood pressure remained low and she presented as pale and jaundiced. A further clinical assessment by the Doctor took place at 8:15pm. Amanda

	became unresponsive and an IV line was inserted to give fluids. An ambulance was called at 8:24pm by which time it was more likely than not that the prolonged low BP made her injuries unsurvivable. 2 further calls at 8:42pm and 10:04pm were made to the North West Ambulance Service and an ambulance attended noted as a category 2. Amanda was taken by ambulance which arrived at 23:14pm and conveyed her to Whiston hospital where she suffered a cardiac arrest. She was transferred to Aintree hospital and discharged from the Mental Health Act detention on 25/10/22. Amanda died on 4/11/22 at Aintree hospital as a result of multiorgan failure due to splenic laceration and liver cirrhosis, the laceration more likely than not from either the deliberate action with the Zimmer frame or the deliberate falls to the floor on the 24/10/22 after the incident, with the unintended consequence of injury to herself which was fatal.
4	**CIRCUMSTANCES OF THE DEATH** See above.
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) During the inquest the court heard evidence from the North West Ambulance Service (NWAS) witness who confirmed that call handlers for the service are not medically trained but receive basic medical training. The system used nationally to categorise calls is reliant upon questions asked and information which is input by the call handler to achieve a categorisation of a call. In this case, there was no evidence the call categorisation was incorrect, however, an ambulance was called on 3 occasions due to Amanda's condition, on the last occasion that call was made by a Doctor on the scene providing care for Amanda, who was of the opinion that he was unable to keep the patient stable due to low blood pressure over a prolonged period. The NWAS witness gave evidence to the court that had the Doctor disagreed with the category 2 classification of the call or sought to escalate his clinical concerns regarding a patient, that he had the ability to challenge that and to request a review by a clinician available to NWAS. The Doctor was unaware that he had the ability to challenge the call handler categorisation and to seek a review by a clinician at NWAS, at which point the nature and seriousness of Amanda's condition could have been further reviewed and clearly understood. At a further course attended subsequently by the Doctor he advised that of 50 Doctors in attendance, only 1 was aware of the ability to escalate concerns regarding a patient and the categorisation of a 999 call to the Ambulance service and subsequent response time. It appears that this is an important fact unknown by many clinicians which would enable a clinician to clinician review of a critical patient and the use and dispatch of ambulance resources to prevent the loss of life in critical cases which are not automatically categorised at the highest level of response.
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 December 19, 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] **North West Ambulance Service NWAS** **Merseycare NHS Trust** I have also sent it to [redacted] 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: 24/10/2024**  **Kate ROBERTS** **Assistant Coroner for** **Liverpool and Wirral**