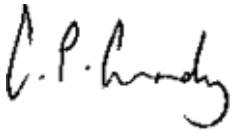
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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 NHS trust**
1	**CORONER** I am Catherine CUNDY, Area Coroner for the coroner area of North Yorkshire and York
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 07 February 2024 I commenced an investigation into the death of Susan Patricia SHIPLEY aged 68. The investigation concluded at the end of the inquest on 22 October 2024. The conclusion of the inquest was that: Susan Patricia Shipley died as a consequence of naturally occurring disease contributed to by injuries sustained while being inappropriately transported in a hospital wheelchair, and on a background of further naturally occurring disease.
4	**CIRCUMSTANCES OF THE DEATH** On the 28th of January 2024 Susan Patricia Shipley, who had critical limb ischaemia and a right below knee amputation, was taken by ambulance to the Emergency Department of Scarborough General Hospital. She was inappropriately deemed fit to sit in a hospital-issue wheelchair. Mrs Shipley required transfer to York District Hospital for specialist vascular assessment. In the process of transfer, Mrs Shipley suffered an accidental fall from the hospital wheelchair, fracturing her right neck of femur. On eventual transfer to York District Hospital, Mrs Shipley consented to high risk surgery to amputate her left leg above the knee and revise her right leg amputation to above the knee, which took place on the 31st of January 2024. Her hip fracture was managed conservatively following orthopaedic assessment. Mrs Shipley developed pneumonia and her condition continued to deteriorate. She died at the hospital on the 4th of February 2024.
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) 1. I heard evidence that Yorkshire Ambulance Service (YAS) use 'fit to sit' assessments of patients attending Emergency Departments (ED) by ambulance, to determine whether they are fit to sit and wait to be assessed by hospital staff, or need to remain on an ambulance stretcher. 'Fit to sit' is thus an important part of YAS's attempts to reduce handover times for ambulances at acute hospitals. I heard evidence from an ED clinician and a senior YAS paramedic that 'fit to sit' assessments should involve a senior practitioner in the ED (such as an ACP or Registrar) going into the waiting ambulance to

	take a brief history from the patient and undertake a brief physical examination to assess the patient's ability to sit and wait in a chair for what is likely to be a considerable period of time. This assessment should be recorded and should involve discussion with the Hospital Ambulance Liaison Officer (HALO) deployed by YAS. 2. Mrs Shipley was a right below knee amputee with an ischaemic/gangrenous left foot and a wheelchair user who was unable to weight bear. Despite this, she was deemed 'fit to sit', and be transported to another hospital, in a hospital issue wheelchair. There was no documentary evidence of any assessment of her fitness to sit made by the paramedics concerned, nor the ACP and HALO who were said to have been involved in it. I found from the evidence of a senior YAS paramedic that any assessment appropriately undertaken could not have concluded that Mrs Shipley was 'fit to sit'. I found that attempting to transport Mrs Shipley in the hospital wheelchair was inappropriate and resulted in her falling from it and sustaining a fractured neck of femur which contributed to her death. 3. My concerns relate to – a) The absence of any documentary evidence that an initial 'fit to sit' assessment was undertaken involving the parties mentioned above; b) The decisiion that Mrs Shipley was 'fit to sit' despite being an amputee and unable to weight bear; c) The absence of any subsequent 'fit to sit' assessment being undertaken by the second ambulance crew transporting Mrs Shipley to York, because of an assumption of fitness to sit, and the role of the HALO in this assumption; d) The absence of evidence that all relevant learning arising from the above has occurred and any actions arising from such learning have been completed, particularly in relation to the first paramedic crew and the HALO; e) The potential risk of death to others in the event of a recurrence of any of the above.
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 23, 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] **York and Scarborough Teaching Hospital** I have also sent it to **Department of Health & Social Care - Prevention of Future Death Reporting** 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: 28/10/2024**  **Catherine CUNDY** **Area Coroner for** **North Yorkshire and York**