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 Derby & Derbyshire Integrated Care Board**
1	**CORONER** I am Sophie LOMAS, Assistant Coroner for the coroner area of Derby and Derbyshire
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 14 December 2023 I commenced an investigation into the death of Vera SPENCER aged 94. The investigation concluded at the end of the inquest on 25 October 2024. The Medical Cause of Death was: 1 (a) Pneumonia (b) Fall 2 Chronic Kidney Disease, Heart Failure The conclusion of the inquest was: Accident
4	**CIRCUMSTANCES OF THE DEATH** On 6th December 2023 Vera Spencer had a fall at her home address. She was able to use her lifeline alarm which notified her next of kin who attended and called the ambulance service. The ambulance service were first contacted at 22.11pm and an ambulance arrived at 09.01am on the 7th December. By that time Mrs Spencer had been on the floor for 11 hours. Mrs Spencer was taken to hospital where x-rays showed that she had sustained a fractured hip and had showed infective changes in her lung consistent with a chest infection. She was commenced on antibiotics for her chest infection and underwent a surgical repair of her hip on 8th December 2023. Post-operatively Mrs Spencer was stable but late in the evening of the 9th December 2023 her condition deteriorated. By 11th December Mrs Spencer developed breathing difficulties; despite treatment her condition continued to deteriorate and she sadly died on 11th December 2023 at Royal Derby Hospital. The court heard evidence that the ambulance service was under severe pressure on the day of Mrs Spencer's fall which was due to a combination of high call volumes and long handover delays at local hospitals. It was not possible to determine on the evidence available whether the long lie whilst awaiting an ambulance contributed to the development of pneumonia or whether earlier ambulance attendance and earlier treatment may have prevented Mrs Spencer's death.
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) At times when the ambulance service is under extreme pressure, individuals who have fallen at home can wait many hours on the floor before paramedics can attend. This is usually because falls are given a lower categorisation by the ambulance service because it is not a life-threatening situation. Resultant long lies can increase the risk of pneumonia, pressure damage and Rhabdomyolysis. The court heard evidence that other than the ambulance service, there is no local falls service or team operating out of hours to assess patients and assist them off the floor following a fall.
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 January 06, 2025. 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 **The family of Vera SPENCER** **East Midands Ambulance Service Governance Team** 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: 11/11/2024**  **Sophie LOMAS** **Assistant Coroner for** **Derby and Derbyshire**