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. Department of Health & Social Care 2. University Hospitals of Northamptonshire 3. East Midlands Ambulance Service (EMAS) 4. South Central Ambulance Service (SCAS)
1	**CORONER** I am Hassan Shah, Assistant Coroner for the coroner area of Northamptonshire.
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 8 January 2025 I commenced an investigation into the death of Lewis Aubrey GARFIELD aged 90. The investigation concluded at the end of the inquest on 27 October 2025. The conclusion of the inquest was that: Mr Garfield died 8th December 2024 at John Radcliffe Hospital as a result of a large spontaneous bleed on the brain. Death was due to natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Garfield suffered an intracerebral haemorrhage at home at midnight on 4th December 2024. He then fell down the stairs suffering various fractures, including to his spine. Mr Garfield lived close to the border between Oxfordshire and Northamptonshire. The 999 call was therefore handled by South Central Ambulance Service (SCAS) but it was the responsibility of East Midlands Ambulance Service (EMAS) to attend. A call at 00.44 hrs was designated by SCAS as category 3 (call response time 120 minutes). At 00:58 hrs, this was upgraded to category 2 (18 – 40 minutes response time). At 02:33 hrs, Mr Garfield is noted to be "fighting for breath" but the designation remained category 2. It was at 05:05 hrs, that the matter was first reviewed by a medically trained clinician (as opposed to a call handler) – the call was then escalated to a category 1 emergency. A double crewed ambulance arrived at 05:40 hrs. Mr Garfield was taken to the John Radcliffe Hospital in Oxford, where he sadly passed away on 8th December 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)

	a) It was not clear if information about the symptoms taken by SCAS was adequate or if it had been recorded or conveyed by them accurately/completely. It was odd that the call was upgraded to category 2, just 14 minutes after being designated a category 3, without any evidence that there had been a change or deterioration. b) The first call was at around 00:44 hours but it was not until over 4 hours later at 05:05 hrs that a medically trained clinician first reviewed the facts, immediately escalating it to category 1. c) The family complained of not being given any guidance on how to deal with the patient pending the arrival of an ambulance e.g. not to move him given the fall down the stairs. d) I understand that nationally, the target time for handover from ambulance to hospital staff is 15 minutes. In the present case, the handover from ambulance to nursing staff at John Radcliffe Hospital took 25 minutes. However, at the same time, the longest handover time at Northampton General Hospital was 5 hours and at Kettering General Hospital it was 7 hours. The Trust lost 115 hours waiting to handover at Northampton over 121 hours at Kettering. e) I heard evidence that steps are being taken to mitigate the impact of pressures in the healthcare system. University Hospitals of Northamptonshire have adopted the '45-minute handover' approach. Despite this, on the day of the inquest on 27 October 2025, average handover times at Northampton General Hospital were 1 hour 11 minutes and I suspect that this will get worse during the full onset of winter pressures. f) The delays getting patients from the Emergency Department (ED) into wards, causes delays taking patients from ambulances into ED, and a knock-on delay getting ambulances back out into the community. These delays persist despite the current actions to mitigate.
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, 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:- [redacted] 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: 28.10.2025**

[redacted]

Mr Hassan Shah
Assistant Coroner for
Northamptonshire