Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **AOC- Patient Safety Specialist** **East of England Ambulance Service NHS Trust** **Whiting Way** **Melbourn** **Cambridgeshire SG8 6NA**
1	**CORONER** I am Robin Weyell assistant coroner, for the coroner area of Norfolk
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 03 October 2025 I commenced an investigation into the death of Edna May WIGGETT aged 85. The investigation concluded at the end of the inquest on 13 March 2026. **The medical cause of death was:** 1a) Heart Failure 1b) Osteoporotic Fractured Neck of Femur (Operated 27.9.25); New Atrial Fibrillation 1c) Fall with Long Lie 1d) 2) Hypertension; Chronic Kidney Disease; Frailty **The conclusion of the inquest was:** Edna May Wiggett never recovered from essential surgery for a fractured hip and other injuries following an earlier fall at her home. The long wait she had lying on the floor waiting for an ambulance before her admission more than minimally contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** On Twenty-Ninth September 2025 at Norfolk and Norwich University Hospital, Colney Edna May Wiggett died from heart failure following surgery after she had had a fall at home. The long wait she had lying on the floor waiting for an ambulance more than minimally contributed to her 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: (1) the failure to re-triage Mrs. Wiggett's case and consider a re-classification following receipt of a second call providing relevant information (an increase in pain) leading to delays in the dispatch of an ambulance.
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 May 13, 2026. 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 Family of Edna May Wiggett I have also sent it to Department of Health and Social Care Care Quality Commission HSSIB Healthwatch Norfolk NHS England 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: 18/03/2026** [redacted] **Robin WEYELL** **Assistant Coroner for Norfolk** County Hall

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