	REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013** (Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026))
1	**CORONER** I am James Bennett HM Assistant Coroner for the coroner area of Birmingham and Solihull.
2	**DATE OF REPORT** 14 September 2026
3	**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.
4	**THIS REPORT IS BEING SENT TO** 1. **Chief Executive, West Midlands Ambulance Service** You are under a duty to respond to this report within 56 days of the date of this report, namely by **9 November 2026**. I, the coroner, may extend the period if an appropriate application is made.
5	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding the publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6	**SUMMARY OF THE CORONER'S CONCERN** West Midlands Ambulance Service have not conducted any form of learning investigation under the Patient Safety Incident Response Framework. The evidence revealed there is likely to be some important learning around assessing the threshold for admitting to hospital a patient who has fallen with reported rib injuries.
7	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe you have the power to take such action.
8	**INVESTIGATION and INQUEST** On 29 January 2026, I commenced an investigation into the death of Sandra Yvonne Savage, aged 73 years. The investigation concluded at an inquest. The **medical cause of death** was 1a Haemorrhage, Traumatic right-sided haemothorax 1b Rib fractures following a fall 1c 1d II Dementia, Severe frailty, Previous cerebrovascular accident **How, when and where** Sandra was admitted to a psychiatric ward in December 2025 subject to Section 2 of the Mental Health Act relating to her advanced dementia. The section expired on 11/01/26. She was at high risk of falling. Around 00:50hrs on 16/01/26 she fell when attempting to sit in a chair hitting her right ribs. The duty doctor advised admission to hospital for a chest x-ray suspecting a rib injury. Paramedics attended at 03:22hrs and their clinical assessment was that Sandra did not require admission to hospital finding no clear traumatic injury and respiratory observations within normal parameters. Around 12:30hrs a second doctor again advised Sandra required hospital admission due to right sided swelling and rib pain. The ambulance service was very busy and paramedics arrived at 07:30hrs on 17/01 and Sandra was admitted to the Queen Elizabeth Hospital Birmingham. An x-ray confirmed minimal traumatic right sided rib fractures but with associated haemothorax impacted by blood thinning medication. She was frail and passed away peacefully around 06:25hrs on 18/01/26. It is not clear that earlier admission would have changed the outcome.

	Conclusion Death was the consequences of an accidental fall, contributed to by blood thinning medication.
9	**CIRCUMSTANCES OF DEATH** As above.
10	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: The evidence revealed a material disparity around the threshold for admitting a patient to hospital who had fallen with reported rib injuries. Two doctors at the psychiatric unit separately advised the patient needed hospital admission because of potential rib injuries, and a Consultant Thoracic Surgeon gave evidence that the real need for hospital admission is the potential for internal bleeding caused by rib fractures. All three doctors felt the threshold for hospital admission was met. On the available evidence it was difficult to reconcile how the attending paramedics at 3:22hrs 16/01/26 came to a different view. In deciding the threshold for hospital admission was not met, the concern is that they did not give adequate consideration/weight to (1) admission had been advised by a doctor, (2) the patient had dementia and may not have been able to communicate effectively, (3) by the time of their arrival pain relief may have masked the real pain, (4) she was taking blood thinning medication, and (5) linked, the real concern is of internal bleeding rather than just rib fractures. Linked, when a second doctor repeated hospital admission was required, the concern is the triage did not appreciate the seriousness and the second ambulance did not arrive for 15+ hours delaying hospital admission. West Midlands Ambulance Service had been informed of the death by the coroner at an early stage. No learning investigation had been conducted. They were not represented at the inquest. My principal concern is West Midlands Ambulance Service have not conducted any form of learning investigation under the Patient Safety Incident Response Framework and the evidence revealed matters of concern indicating there is likely to be some important learning that may prevent future deaths.

11	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every interested person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Family. 2. Mental Health Trust. 3. Alzheimer's Society. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE  James Bennett Assistant Coroner for Birmingham and Solihull