REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **Dr Anthony MARSH** **Chief Executive** **East of England Ambulance Service** **Ambulance Headquarters** **Building 1020** **Cambourne Business Park** **Cambourne** **Cambridgeshire. CB23 6EB**
1	**CORONER** I am **Mr Tom Osborne**, Senior Coroner, for the Coroner Area of Bedfordshire and Luton
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. **http://www.legislation.gov.uk/ukpga/2009/25/schedule/5**
3	**INVESTIGATION and INQUEST** On 12th November 2013 I commenced an Investigation into the death of **Albert James HAND** aged 79. The Investigation concluded at the end of the Inquest on 8th January 2014. The Conclusion of the Inquest was that the deceased had died as a result of an 'accident' - the medical cause of death being: 1(a) Subarachnoid Haemorrhage and Subdural Haemorrhage
4	**CIRCUMSTANCES OF THE DEATH** Albert Hand suffered a fall at around 13.00 hours on 1st November 2013 at the Arndale Shopping Centre in Luton. A call was made to the Ambulance Service via 999 and a Paramedic attended at 13.32 hours who conducted an assessment and recorded a Glasgow Coma Scale (GCS) of 11. The Paramedic then requested a "Hot 2" transfer to hospital. The "Hot 2" ambulance arrived at 14.15 hours and left the scene at 14.37 hours, arriving at the Luton & Dunstable Hospital at 14.51 hours, almost an hour and a half following the original call. His GCS had then fallen to 7. The Clinical Manager for the Ambulance Service explained in his evidence that a patient could be waiting for up to three hours and "……the waits are getting longer". Priority is given to diverting an ambulance to an incident where the person has suffered a respiratory or cardiac arrest, even in situations where the patient has suffered a head injury
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) That a patient who has suffered a head injury has to wait for over one and a half hours to be conveyed to hospital (2) That there are insufficient ambulance crews in the Luton and Bedfordshire area to meet the emergency needs of the community. (3) That the Protocols in place for dealing with emergency calls are putting patients at risk and may result in future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the East of England Ambulance Service, 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 the **7th March 2014**; 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 Person(s): [redacted] I have also sent it to Luton MP's who may find it useful or of interest - **Mr Gavin Shuker and Mr Kelvin Hopkins** I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish, either or both, in a complete, redacted or summary form. He may also 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 this 9th day of January 2014** **Tom OSBORNE** **Senior Coroner** **Bedfordshire & Luton**