**ANNEX A**

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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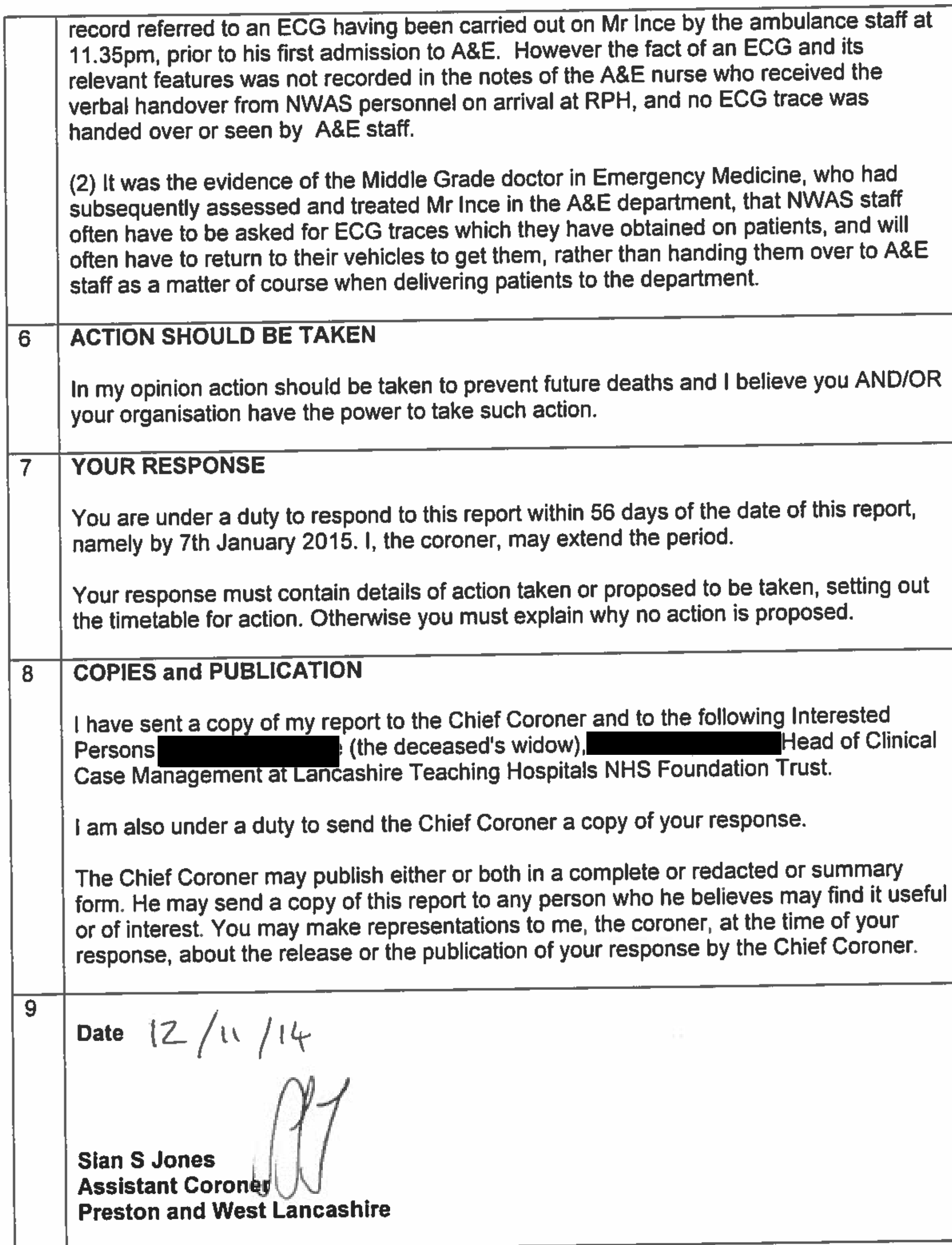
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>[redacted]<br>**Acting Head of Legal Services**<br>**North West Ambulance Service NHS Trust** |
| 1 | **CORONER**<br><br>I am Sian Jones assistant coroner, for the coroner area of Preston and West Lancashire |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 27 June 2014 I commenced an investigation into the death of David Anthony Ince. The investigation concluded at the end of the inquest on 23rd October 2014. The conclusion of the inquest was<br><br>medical cause of death<br><br>1(a) Hypoxic-ischaemic encephalopathy<br>1(b) Cardiac arrest (resuscitated)<br>1(c) Ischaemic heart disease<br><br>and narrative conclusion<br><br>David Anthony Ince was admitted by ambulance to Royal Preston Hospital at 00.06 on 26/06/14 having suffered a collapse at home. The clinical history and investigations suggested that the event was a syncopal episode of the sort Mr Ince had been suffering for some months. He was discharged in the early hours but shortly after having arrived home, he suffered a cardiac arrest which was unsurvivable despite readmission to hospital. |
| | **CIRCUMSTANCES OF THE DEATH**<br><br>See narrative conclusion above. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) In the course of the Inquest hearing, it became apparent that the NWAS electronic |



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| | record referred to an ECG having been carried out on Mr Ince by the ambulance staff at 11.35pm, prior to his first admission to A&E. However the fact of an ECG and its relevant features was not recorded in the notes of the A&E nurse who received the verbal handover from NWAS personnel on arrival at RPH, and no ECG trace was handed over or seen by A&E staff.<br><br>(2) It was the evidence of the Middle Grade doctor in Emergency Medicine, who had subsequently assessed and treated Mr Ince in the A&E department, that NWAS staff often have to be asked for ECG traces which they have obtained on patients, and will often have to return to their vehicles to get them, rather than handing them over to A&E staff as a matter of course when delivering patients to the department. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th January 2015. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons (the deceased's widow), Head of Clinical Case Management at Lancashire Teaching Hospitals NHS Foundation Trust.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Date** 12/11/14<br><br>**Sian S Jones**<br>**Assistant Coroner**<br>**Preston and West Lancashire** |