REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Secretary of State for Health.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 22nd December 2014 I commenced an investigation into the death of **Elizabeth Anne Lester** dob 17th June 1945. The investigation concluded on the 14th May 2015 and the conclusion was one of **Misadventure**. The medical cause of death was **1a Pulmonary Embolus 1b Deep vein thrombosis 1c Immobility due to right total knee replacement for osteoarthritis**
4	**CIRCUMSTANCES OF THE DEATH** **This lady underwent a total knee replacement at Tameside General Hospital on the 23rd November last. She needed to be readmitted thereafter as an emergency and because of the badly constructed algorithms used by the Ambulance Service, there was a significant delay in properly prioritising her transportation to hospital.**
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. – **As per National practice, the North West Ambulance Service uses Advanced Medical Dispatch System to prioritise calls, based on the answers to scripted questions. During the first call the call-handler asked the relevant questions and followed the "breathing difficulties" card. This card does not include any question as to whether the patient is suffering any chest pains. The call was allocated a green response and the "high volume script" was also given. In fact the patient was short of breath AND did have chest pains, but this was never enquired about. On the second call to the Ambulance service, this aspect was asked about and the call was escalated to a Red response.** **It is my firm belief, having come across this same issue in a number of inquests, that there is an omission in the 'card' for ALL breathing difficulties and it MUST be amended to include a question about chest pain. Breathing difficulties are frequently as a result of compromised heart and/or lung function and this should be queried.** **I am told that the local ambulance service cannot alter the wording used but that this must be done by the suppliers of the software.**

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **24th July 2015**. 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 namely [redacted] **(son of the deceased)** and **North West Ambulance Service**. 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 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	**29th May 2015** **John Pollard, HM Senior Coroner**