ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **North East Ambulance Service NHS Foundation Trust** 2. **Department of Health** 3. **Care Quality Commission**
1	**CORONER** I am Carly Elizabeth Henley, assistant coroner, for the coroner area of North Northumberland.
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 9.1.15 I commenced an investigation into the death of Barbara Patterson aged 67 years. The investigation concluded at the end of the inquest on 18.5.15. The conclusion of the inquest was the following narrative conclusion: "On the balance of probabilities Barbara Patterson died on 2.1.15 at Wansbeck General Hospital of a cerebral stroke suffered on 1.1.15, which resulted in an unwitnessed low level fall from a stair lift in her home. Her death was probably accelerated by a lack of timely administration of CPR due to the late arrival of an ambulance and the lack of appropriate medical advice for the family in the intervening period."
4	**CIRCUMSTANCES OF THE DEATH** Barbara Patterson suffered a large cerebral stroke whilst at home on 1.1.15. This caused her to fall a short distance from a stair lift in her home, (an unwitnessed fall). Her husband was at home, heard the fall and summonsed help from their daughter who lived a short distance away. She immediately called 999. The ambulance took 15 minutes to arrive and in the intervening period the family were not given appropriate medical advice by the call handler. The lack of CPR in the intervening period is likely to have accelerated Mrs Patterson's death. She died at Wansbeck Hospital on 2.1.15. The cerebral stroke was an unsurvivable event but she may have lived for a few more days or even weeks had CPR been administered.
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. The failure by the Call Handler to give timely advice in respect of CPR. 2. During the inquest evidence was given that the Pathways system, a

	computerised system piloted in the North East and since rolled out for use by 6 other Healthcare Trusts nationally, has a fault in that it does not advise non clinical call handlers to issue CPR advice unless a patient has stopped breathing. This fails to recognise the need for CPR in cases of Aganol (heavy/noisy breathing which is insufficient to sustain life). This fault was pointed out to Pathways by the Clinical Section Manager for North East Ambulance Service NHS Foundation Trust.prior to the latest update being installed in early 2014 (Update 9). Pathways refused to amend the system. That fault remains in place to date. 3. The failure by the ambulance dispatcher to dispatch an ambulance closer to the deceased's location 4. The target time for the arrival of the ambulance was 8 minutes, this was breached. The ambulance did not arrive for 15 minutes. 5. During the inquest evidence was given that there is a national shortage of paramedics, which is particularly acute in the North East. 6. During the inquest evidence was given that ambulance availability is being jeopardised by crews being delayed at hospital when handing patients over to Accident and Emergency staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 14.7.15. 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: Barbara Patterson's husband and daughter. 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	**[DATE]** 21.5.15 **[SIGNED BY CORONER]** [redacted]