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:** **East of England Ambulance Service NHS Trust** **Irwin Mitchell Solicitors** **Weightmans Solicitors** **Southend Hospital Legal Services** **Bevan Brittan Law Firm**
1	**CORONER** I am Mrs Caroline Beasley-Murray, HM SENIOR Coroner, for the area of Essex
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 29th January 2015 I commenced an investigation into the death of Steven David Jackson. The investigation concluded at the end of the inquest on 27th October 2015. The conclusion of the inquest was a narrative verdict. The cause of death was 1a) Acute Epiglottitis 0 beta haemolytic streptococcus group C as causative organism. Narrative conclusion:- *At 6.26am on the 5th March 2014, Steven Jackson attended Southend Hospital and was assessed by an out of hours doctor. At around 10:00am ambulance personnel were called to his home and gave him advice. At 1:00pm ambulance personnel again attended after he had collapsed. He was conveyed to Southend Hospital where he died at 14:26pm. There were very serious failings in the care Mr Jackson received from the ambulance staff. With appropriate, timely treatment, Mr Jackson would most likely have survived.*
4	**CIRCUMSTANCES OF THE DEATH** **Please see box 3 above.**

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 paramedic who attended at around 10:00am gave evidence which indicated that she did not seem to have learned from the events in March 2014. 2. She had not used the sepsis screening tool effectively in March 2014 and the court is not confident that she would, in similar circumstances again, use it effectively. 3. There needs to be effective training of ambulance staff in the use of the tool and in the circumstances as to when it is appropriate to convey a patient to hospital.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 15th January 2016. 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. **Irwin Mitchell Solicitors** **Weightmans Solicitors** **Southend Hospital Legal Services** **Bevan Brittan Law Firm** 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	**2nd November 2015** **Mrs Caroline Beasley-Murray**