HM CORONER
Central Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Medical Director, East Midlands Ambulance Services**
1.	**CORONER** I am Stuart P G Fisher, Senior Coroner, for the coroner area of Central Lincolnshire, Lindum House, 10 Queen Street, Spilsby, Lincolnshire, PE23 5JE.
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/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 29 August 2014 I commenced an investigation into the death of Stuart Knight. The investigation concluded at the end of the inquest on 26 August 2015. The conclusion of the inquest was that Mr Knight died as a result of an accident, the medical cause of death being: 1a. Head Injury with Subarachnoid Subdural Haemorrhage and Skull Fracture 2. Alcohol Excess
4.	**CIRCUMSTANCES OF THE DEATH** In the early hours of 29 August 2014, Mr Knight was found by [redacted] lying in a road in Wainfleet. Initially he appeared to be unconscious. [redacted] immediately made a 999 call and requested the attendance of an ambulance. [redacted] call was timed at 00:04:32, he was informed that the ambulance service was busy and that there would be a delay in their arrival. This call was never cancelled. [redacted] stated that some minutes after he made his initial call to the ambulance service Mr Knight (who was apparently intoxicated) managed to stand up. [redacted] went on to state that he then observed Mr Knight fall backwards hitting his head on the road with significant impact which caused a loud "popping" sound and resulted in Mr Knight becoming unconscious. [redacted] concern was such that at 00:24 he made a further call to the ambulance service and outlined details of Mr Knights fall. Although [redacted] spoke with ambulance personnel on the telephone it was not until 01:15 that a Fast Response Vehicle arrived at the scene. It appeared that the Paramedic in the FRV assessed Mr Knights condition and then spoke on the radio to the ambulance service requesting the attendance of a double-crewed ambulance which did not arrive at the scene until 01:28. In summary, from the time that [redacted] made his first call to EMAS it took 1 hr and 11 mins for the FRV to arrive at the scene and 1 hr and 24 mins had elapsed between the 1st call being made and the arrival of the double crewed ambulance. Mr Knight was taken to Pilgrim Hospital and arrived at 02:02 and died later that day.

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. – (I) Significant and unacceptable delays occurred in despatching an ambulance to a patient who was unconscious and had clearly suffered a serious head Injury. Such delay is potentially highly prejudicial to those who rely upon the services provided by EMAS. (II) (III) (IV) (V)
6.	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 November 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 (a) [redacted] (daughter of deceased). 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.
	22 September 2015 ..... **S P G Fisher** **Senior Coroner**