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. Richard Henderson, Chief Executive, East Midlands Ambulance Service NHS Trust ('EMAS')** **2. Simon Stevens, CEO, NHS England** **3. [redacted] NHS Hardwick CCG** **4. Jim Mackey, CEO NHS Improvement** **5. The Rt Hon Earl Howe, Dept of Health**
1	**CORONER** I am Heidi Connor, assistant coroner for the coroner area of Nottinghamshire.
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 25 February 2016, I commenced an investigation into the death of Peter Scott, aged 78. The investigation concluded at the end of the inquest on 18 May 2016. The conclusion of the inquest was natural causes. The medical cause of death was : 1a Hypovolaemic shock 1b Rupture of a dissection of the thoracic aorta 2 Ischaemic and hypertensive heart disease
4	**CIRCUMSTANCES OF THE DEATH** Mr Scott suffered an aortic dissection at home on 3 December 2015. Mr Scott had a pendant which he wore around his neck, and he and he used this to summon help via Nottingham City Homes ('NCH'). NCH contacted EMAS at 01.34 hrs. EMAS was told that Mr Scott had fallen, was in pain, and was on the floor. The call was prioritised as Green 2, and as such, the target was to reach him within 30 minutes. In fact, the call was allocated to a double-crewed ambulance at 0342 hrs, and they arrived on scene at 0356 hrs. The arrival time was almost 5 times longer than the target time. We heard evidence that EMAS had invoked a Capacity Management Plan ('CMP') (level 4) at this time, and as such, lower priority calls (including this one) were taking longer to respond to. We also heard that NCH should have re-contacted EMAS between 11 and 15 minutes after the first call, to advise that Mr Scott had become unresponsive. EMAS evidence was that the call would then have been prioritised as Red1 or Red 2, with a target

	response time of 8 minutes. Given the resource issues and CMP in place at that time, it is not possible to be certain when an ambulance would have arrived if the call had been re-prioritised. I found it unlikely, on the balance of probabilities, that earlier ambulance attendance would have changed the outcome for Mr Scott.
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 remain very concerned about resource issues for this ambulance service. I raised similar concerns in a Prevention of Future Deaths Report in the case of MG, dated 11 May 2016. We heard evidence from a senior manager at EMAS during the inquest. I asked the service to advise me to what extent they had had to invoke Capacity Management Plans in the last 12 months. I was advised that EMAS has had to invoke such a Plan (to at least level 3) for 9 out of the last 12 months. The issue in this case and that of MG was essentially a matter of resource. In essence, I found that there is only so much an ambulance service can do where they simply do not have an ambulance to send. Demand is clearly greater than the resources they have most of the time, given that a CMP has been in place for 75% of the last 12 month period. I am very concerned that this poses a serious risk to the public served by this ambulance service. We heard also that recruitment is an ongoing problem – which may be exacerbated by the huge demand placed on its employees by this resource issue. Finally, I was made aware that one of the key problems in ensuring ambulance availability is delayed handover of patients at hospitals. I believe the trust is already working to improve this, and I include EMAS in this report in this respect only. Other recipients of the report are required to respond with regard to matters of resourcing only. 1. I consider that there is a risk of future deaths as set out above unless an urgent review of resources is undertaken. 2. Consideration should be given to strategies to improve handover times at hospitals.
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 22 July 2016. I, the coroner, may extend the period. A response is expected from each of the recipients, although the coroner may accept a joint response from recipients 2 to 5, provided it is clear that all have agreed this. 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 : 1. Family of Mr Scott 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	**26 May 2016** ***H.Connor***