CORONER'S OFFICE
AREA OF HERTFORDSHIRE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Claims and Inquest Facilitator East of England Ambulance Service Hammond Road Bedford Bedfordshire MK41 0RG
1	**CORONER** I am Geoffrey Sullivan, Senior Coroner for Hertfordshire
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 the 26th January 2016 Brian Mills fell on the stairs at home sustaining multiple injuries including a number of broken ribs. An ambulance was called at 11:16 hours but a rapid response vehicle arrived at 13:23 hours. An ambulance arrived at 13:38 hours and conveyed Brian Mills to the Lister Hospital. He was deemed unsuitable for surgical intervention and treated conservatively with intravenous antibiotics and fluids. Brian Mills died at 11:15 hours on the 13th April 2016. I heard evidence from the treating doctor and the pathologist that the delay in the ambulance arriving did not, in this case, cause or contribute to the death.
4	**CIRCUMSTANCES OF THE DEATH** Brian Mills was an 88yr old man on warfarin who had fallen and had a bleeding head wound who had to wait over two hours for an ambulance. On that day, the East of England Ambulance Service log revealed that the Bedford Emergency Operation Centre had a number of calls unassigned prior to and during the time the call for Mr Mills had been received: 10:44hrs: eight outstanding emergency calls, longest waiting time of 1hr 52 minutes. 10:48hrs: thirteen outstanding emergency calls, longest waiting time of 3hr 7 minutes. 12:47hrs: twenty four outstanding emergency calls, longest waiting time 3hr 53 minutes.

5	**CORONER'S CONCERNS** I heard evidence that this was not an unusual amount of outstanding calls or an unusual level of waiting time. This was the position on the 26th January 2016 and I heard evidence that this is still the position now. 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 **MATTER OF CONCERN** is as follows. – (1) Consistently high levels of outstanding emergency calls and waiting times that far exceed the service's own target response times are likely to put lives at risk.

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 12 January 2017. 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, [redacted] and the East and North Hertfordshire Trust. 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	Dated 17 November 2016 Signature_____ Senior Coroner for Hertfordshire