**Ms N J Mundy**
**Senior Coroner for South Yorkshire (East District)**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: The Chief Executive, Yorkshire Ambulance Service NHS Foundation Trust,** Trust Headquarters, Springhill, Brindley Way, Wakefield 41 Business Park, Wakefield WF2 0XQ |
| 1 | **CORONER**<br><br>I am Ms N J Mundy, Senior Coroner for South Yorkshire (East District) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br>On 11/04/2016 I commenced an investigation into the death of Lyndsey Holt, 36 . The investigation concluded at the end of the inquest on 29 March 2017. The conclusion of the inquest was Natural Causes. The cause of death was 1a. Shock and haemorrhage due to 1b. Perforated Gastric Ulcer. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Miss Holt was 37 weeks pregnant with her third child. There had been no complications during that pregnancy save that she had suffered from severe and painful varicose veins. In 2011 Miss Holt had been prescribed with methadone following a telephone conversation with the prescribing GP who considered that her reported history included reference to there having being a lengthy dependence on Codeine and also that she had taken Oxycodone and Tramadol. Specific details of the frequency of usage and amount taken could not be provided to the court. The dose of methadone had been significantly reduced during Miss Holt's second and third pregnancies. It appeared that as well as methadone, Miss Holt took paracetamol for pain relief of the varicose veins and when particularly severe, took her partner's Oxycodone medication. On the 2nd April 2016 Miss Holt collapsed at 18:55 due to a gastric ulcer having perforated and there being catastrophic bleeding thereafter. She was conveyed by ambulance to the Rotherham Hospital. On leaving the address a pre-alert was requested from the ambulance crew via Control but Control failed to pass the pre-alert on to the receiving hospital. Had they done so clinicians at Rotherham would have been aware of Miss Holt's impending arrival, likely timing of arrival and the seriousness of the situation they were about to face. Once Miss Holt arrived at the A&E Department of the Rotherham Hospital an emergency caesarean section was rapidly performed, extensive resuscitation measures put in place, she underwent a splenectomy, repair of a ruptured gastric ulcer and towards the end of her life a hysterectomy in a last ditch effort to try and save her. The overwhelming coagulopathy she had developed and shutting down of organs led to her death on the morning of the 3rd April 2016 from shock and haemorrhage due to a perforated gastric ulcer. |

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| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>I have concerns regarding the reliability of the pre-alert system, particularly where Control have responsibility for activating such an alert and passing on of relevant information, as follows:<br><br>(1) Absence of systems to audit the effectiveness and reliability of the pre-alert system.<br>(2) A lack of knowledge/training of staff in Control to equip them with the skills to undertake reliable actioning of pre-alert requests, the importance of doing and conveyance of all relevant clinical information. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you The Chief Executive, Yorkshire Ambulance Service NHS Foundation Trust have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 May 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] Messrs Browne Jacobson, AVMA and Messrs DAC Beachcroft.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 29 March 2017<br><br>Signature_____<br>Senior Coroner for South Yorkshire (East District) |

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