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.** Rt Hon Jeremy Hunt MP, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London, SW1A 2NS **2.** [redacted], Chair of the Association of Ambulance Chief Executives, 32 Southwark Bridge Road, London SE1 9EU
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 21st April 2015, an investigation was commenced into the death of Kathryn Verina Richmond, born on the 28th March 2015. The investigation concluded at the end of the Inquest on the 8th November 2017. The Medical Cause of Death was: 1a Hypovolemic Shock 1b Spontaneous Ruptured Spleen 1c Infectious Mononucleosis Infection The conclusion of the Inquest was that Kathryn Verina Richmond died as a consequence of naturally occurring disease, where there was a delay in her receiving necessary lifesaving treatment.
4	**CIRCUMSTANCES OF THE DEATH** On the 21st April 2015, the deceased, who had approximately 12 months previously suffered with glandular fever, collapsed at her home address at [redacted] An ambulance was called immediately at 0.14 hours. South West Ambulance Service Trust (SWAST) initially categorised the call as a Red 2 call and an ambulance was dispatched at 0.15 hours. Due to insufficient probing on the call, by the end of the call it was downgraded to a Green 2 call and the ambulance was stood down at 0.21 hours. A further call was made to SWAST by the deceased's parents at 0.41 hours and the call was

categorised as a Red 2 call and an ambulance was dispatched at 0.45 hours. A clinical review was then carried out with insufficient probing and the call was then downgraded to a Green 2 call and the ambulance dispatched was stood down at 0.57 hours. An ambulance arrived at the deceased's home address at 01.39 hours and she was taken to Poole Hospital, Poole where she arrived at 02.17 hours. She went into cardiac arrest and following resuscitation was taken to theatre and underwent a laparotomy which revealed a ruptured spleen. Despite receiving necessary lifesaving treatment her condition deteriorated and she died that morning.

Between 0.00 hours and 02.00 hours on the 21st April 2015 the demand for ambulances with SWAST was 29% higher than predicted, there were 14 ambulances running and at times up to 6 ambulances were on meal breaks at the same time and therefore unable to attend calls.

5 **CORONER'S CONCERNS**

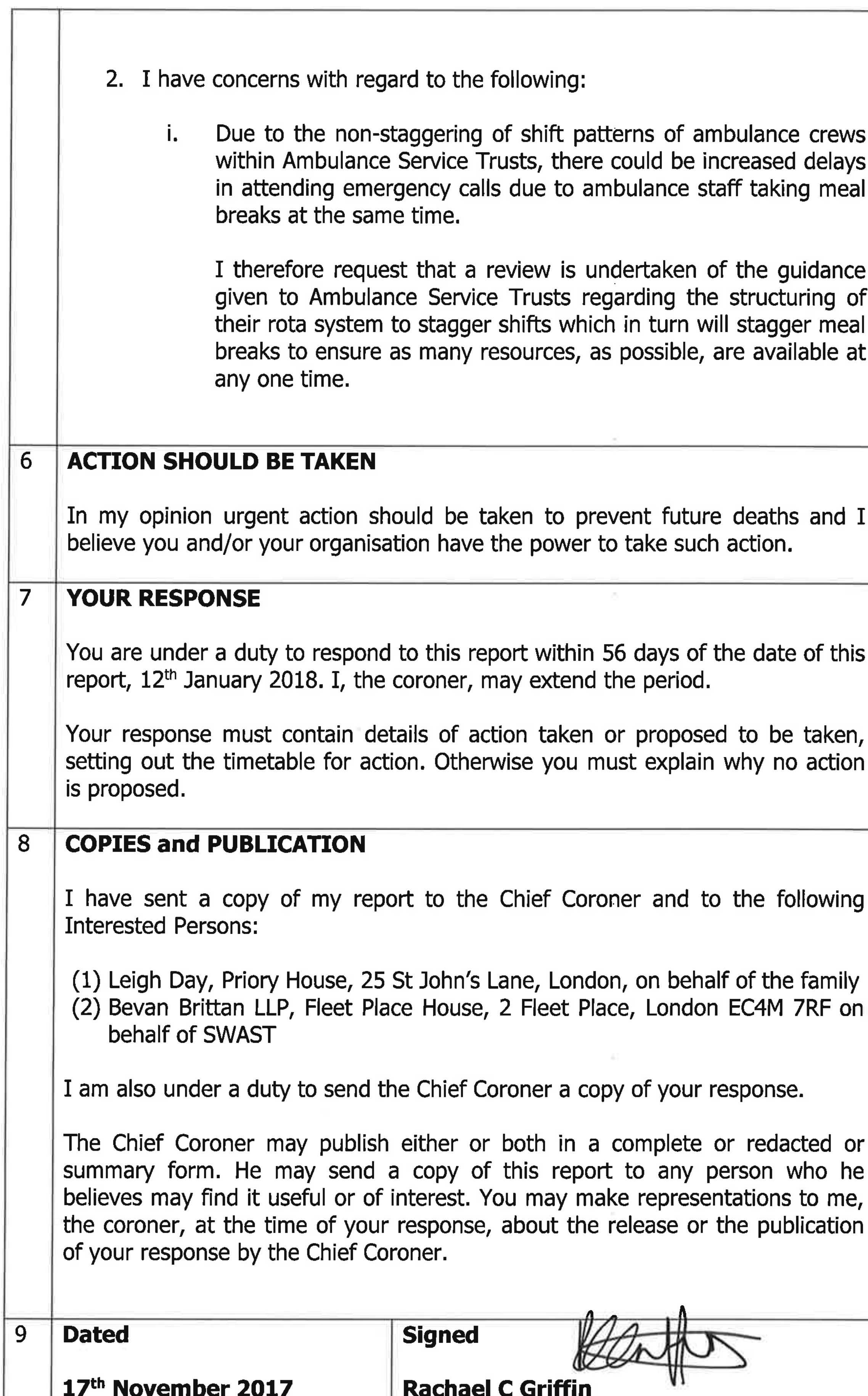
During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.
The **MATTERS OF CONCERN** are as follows:

1. During the inquest evidence was heard that:

    i. At the time of Miss Richmond's death, the South West Ambulance Service Trust (SWAST) did not operate staggered shifts for their ambulance staff which meant that their meal time breaks to be taken in line with European Working Time Directives, fell at a similar time. The result of this was that the number of available ambulances running at certain times was significantly reduced. On the evening of Miss Richmond's death there were 14 ambulances running and for a period there were 6 ambulances on meal breaks at the same time meaning they were unable to attend calls.

    ii. SWAST undertook a trust wide rota review following Miss Richmond's death which has resulted in the staggering of shifts for ambulance crew. This has resulted in the number of ambulances taking meal breaks at any one time being reduced and more resources being available to attend calls. This will reduce the delays in attending emergency calls and could therefore prevent future deaths.

    iii. Evidence was given that within England and Wales other Ambulance Service Trusts are still be operating on non-staggered shift patterns which means that there is a risk that resources are not being used as efficiently as they could be and that there could be unnecessary delays in crews attending emergency calls in those Trust areas.



	2. I have concerns with regard to the following: i. Due to the non-staggering of shift patterns of ambulance crews within Ambulance Service Trusts, there could be increased delays in attending emergency calls due to ambulance staff taking meal breaks at the same time. I therefore request that a review is undertaken of the guidance given to Ambulance Service Trusts regarding the structuring of their rota system to stagger shifts which in turn will stagger meal breaks to ensure as many resources, as possible, are available at any one time.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 12th January 2018. 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: (1) Leigh Day, Priory House, 25 St John's Lane, London, on behalf of the family (2) Bevan Brittan LLP, Fleet Place House, 2 Fleet Place, London EC4M 7RF on behalf of SWAST 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** **17th November 2017**	**Signed** **Rachael C Griffin**