	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Will Hancock, Chief Executive South Central Ambulance Service**
1	**CORONER** I am Mr Tom Osborne, HM Senior Coroner for Milton Keynes.
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 2nd February 2017 I commenced an investigation into the death of Peter (Peirce) Cotter, aged 84. The investigation concluded at the end of the inquest on 22nd June 2017. The conclusion of the inquest was the he died as the result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered an un-witnessed fall at home on the 27th January 2017. He suffered a head injury and a fractured hip. He underwent surgery for his hip on the 31st January and his cause of death was reported to us as: 1a) Myocardial Infarction 1b) Ischaemic Heart Disease 2) Fractured Femur (operated)
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. – During the course of the evidence it became apparent that Mrs Cotter had telephoned emergency services on 27th January 2017 and reported that her husband had had a fall, hit his head and hurt his hip. My concern is that the clinical decision support software system did not appear to register that Mr Carter had suffered a head injury. He was receiving anticoagulant drugs and even a minor head injury could have had catastrophic results if the head injury was not recognised and treated. I believe that there should be a review of the triage system to ensure that all head injuries are recognised and treated as emergencies.

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 15th November 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 • The family of Mr Cotter 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 20th September 2017 Signature_____ Tom Osborne Senior Coroner for Milton Keynes