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. **John Mothersole, Chief Executive, Sheffield City Council.** 2. **[redacted] Registered Manager, City Wide Alarms,**
1	**CORONER** I am Angharad Davies, assistant coroner, for the coroner area of South Yorkshire, West.
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 14 February 2018 I commenced an investigation into the death of Allan Herbert Shepard age 89. The investigation concluded at the end of the inquest on 5 October 2018. The conclusion of the inquest was that Mr Shepard' death was an accident and he died from positional asphyxia.
4	**CIRCUMSTANCES OF THE DEATH** Mr Shepard was 89 years of age and vulnerable due to a number of health conditions. His family had arranged for him to be supported by City Wide Care Alarms Service, which is a service that Mr Shepard paid for. He had this service installed at his home to enable him to have immediate access to an operator who could provide a Responder service to assist Mr Shepard if he ran into difficulties. On 8 February 2018 Mr Shepard fell at home whilst being assisted out of his wheelchair, in a hoist, by his son. His son alerted the City Wide Care Alarm call centre to seek assistance. Mr Shepard's call was logged for the Responders to attend. The stated response time for Responders is 30 minutes. However, there are usually only two responder teams on duty to service the whole of Sheffield. Usually these crews are made up of two people so that they can respond to all situations including falls. On 8 February 2018 this occasion one crew was made up of only one person which meant that they were unable to be sent to respond to falls. Therefore, the operator allocated Mr Shepard's fall to the ambulance service which had a 4 hour wait time. Whilst Mr Shepard was waiting, trapped in his hoist, for assistance he ran into difficulties with his breathing. His son communicated this to the operator and Mr Shephard's call was given a higher priority by the ambulance service. But by the time the ambulance crew attended at Mr Shepherd's address he had already lost consciousness due to

	positional asphyxiation and died later that day in hospital. His death could have been prevented.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) City Wide Care Alarm Service's own guidance requires where there has been a fall a response should be provided within 30 minutes. During the time period when Mr Shepard was waiting for a response, there were two units available, However, one of the units was made up of only one person. The two person unit was engaged answering other calls in the 30 minutes following Mr Shepherd's alert. The one person responder unit was available to attend calls during this 30 minutes period but could attend a fall to provide assistance. Although the ambulance was contacted their response time was given as 4 hours. This 50% reduction in responders available to answer calls may risk further deaths when a person has suffered a fall. Therefore, City Wide Care Alarm Service is invited to consider its staffing levels and systems for providing cover. It is also invited to reconsider its policy regarding one person responder units when the injured person is already attended by someone else who may be able to assist. (2) The information that had been provided to the call handling centre by City Wide Care Alarms about Mr Shepard and his family situation had not been updated since 2015. On this occasion Mr Shepard was being assisted by his son who himself had a visual impairment. Mr Shepard junior was struggling to see the difficulty his father was in. This is important information that may allow operators to prioritise calls and/or provide more complete information to the emergency services to allow them to accurately prioritise the call. Updated information about Mr Shepard was available to City Wide Care Alarms but had not been passed on to their third party call centre contractors. It would be helpful if the information could be updated when there is a significant change and City Wide Care Alarms is invited to consider how this can be done.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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, namely by 19 December 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 – [redacted] (daughter) 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	**23 October 2018** **Angharad Davies**