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BY EMAIL ONLY:
coroners.office@manchester.gov.uk

Mr N Meadows
HM Senior Coroner
Manchester City

Headquarters
Ladybridge Hall
399 Chorley New Road
Bolton
BL1 5DD

Tel: 01204 498400

www.nwas.nhs.uk

29 March 2019

Dear Mr Meadows,

INQUEST TOUCHING THE DEATH OF MRS MILLWARD-WINTER.

I refer to the Regulation 28 Report which Assistant Coroner Galloway issued at the conclusion of the inquest touching upon the death of Marie Millward-Winter.

Firstly, I know that you will share a copy of this response with Mrs Millward-Winter's family and on behalf of the Trust I wish to express my sincere condolences.

In relation to the Regulation 28 Report, I wish to draw to your attention the fact that the Trust was not notified of the inquest date, NWAS statements were read in to evidence and the Trust was not granted Interested Person status and as such was not legally represented at the hearing or in receipt of coronial disclosure.

As you will be aware, pursuant to Regulation 28(3) of The Coroners (Investigations) Regulations 2013 as re-stated within the Chief Coroners Guidance No. 5, it is a pre-condition to making a report that the *"coroner has considered all [emphasis added] of the documents, evidence and information and that in the opinion of the coroner is relevant to the investigation".*

Whilst by this letter the Trust provides its response to the Regulation 28 Report, it takes the view that the issue of a Regulation 28 Report was premature. The Trust was not afforded the opportunity to provide additional evidence/clarification on those matters which were raised during the course of the hearing and which gave rise to the concerns alluded to within the Regulation 28 Report.

The Trust considers that, in the first instance, it ought to have been given the opportunity to provide a response to any concerns by letter. If, following consideration of that letter, the Coroner still took the view that they were under a duty to issue a Regulation 28 Report, one should have been issued at that point.

The Trust's Head of Legal Services has endeavoured to speak with the crew members who attended to Mrs Millward-Winter to obtain their account of any exchange with the nursing home staff in relation to the administration of drugs, particularly Apixaban, prior to conveying her to hospital. [redacted] still works at the Trust and is now a HCPC Registered Paramedic.

Unfortunately, [redacted] is no longer with the Trust and we have been unable to make contact with her.

Despite the passage of time [redacted] recalls the incident and also the discussion that took place between him and the care home staff in relation to the administration of the patient's own medication. At no time during that discussion was the administration of anti – coagulant medication mentioned. He recalls that Mrs Millward-Winter was hypertensive and the staff mentioned that she had not had her routine medication.

[redacted] recollection is that only hypertensive medication was administered together with the patient's own paracetamol and codeine; this administration of this medication was duly noted on the Patient Report Form (PRF). Whilst the PRF records that Mrs Millward-Winter had been prescribed blood thinners, the administration of any anti-coagulant medication is not recorded on the PRF.

[redacted] recollection is that there was no discussion in relation to the administration of anti-coagulant medication for two reasons; firstly, Mrs Millward-Winter was being conveyed to the hospital because she had suffered a head injury *and* was taking blood thinning medication and secondly, advising on the administration of an anti-coagulant was outside of his scope of practice as an Emergency Medical Technician (EMT).

An EMT is not a HCPC registered professional and they therefore have a limited scope of practice. EMT's are trained to recognise the signs and symptoms of a number of conditions and administer six medications to treat these conditions and it would be out of an EMT's scope of practice to advise beyond those, including Apixaban.

In an event where an EMT, or indeed any NWAS clinician, is asked a question which is outside of their scope of practice, the Trust's procedures require that senior clinical advice is sought from the Trust's 24 hour clinical support hub which is based within its control centre.

An Advanced Paramedic has provided an overview in light of the Regulation 28 Report and has noted that Mrs Millward-Winter was resident in a nursing home. In their view, the nurse on duty at the unit would supersede an EMT in respect of which medication should be administered and at what point.

Whilst the Trust considers that the Regulation 28 Report was issued prematurely that in no way alters the fact that the Trust takes any concerns raised in this way very seriously and I hope that I have responded to the concerns raised and provided assurance that the Trust has appropriate protocols and procedures in place.

Finally, I am aware that Regulation 28 Reports and responses are published on the Chief Coroner's website. In light of the matters discussed in this letter, namely the Trust's view that the Regulation 28 report was issued prematurely the Trust respectfully asks that in this instance, neither the Regulation 28 report nor this response are so published.

If you have any further questions arising from the contents of this letter, please do not hesitate to contact the Trust's Legal Services Team.

Yours sincerely

M Forrest

Michael Forrest FCIPD
INTERIM CHIEF EXECUTIVE