C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Buckinghamshire Healthcare NHS Trust** **2. South Central Ambulance Service**
1	**CORONER** I am CRISPIN GILES BUTLER, Senior Coroner, for the coroner area of Buckinghamshire
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/pdfs/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12th July 2018 I commenced an investigation into the death of Joyce Phoebe Mary LONG. The investigation concluded at the end of the inquest on 19th December 2018. The conclusion was that Mrs Long died as a result of an accident. The medical cause of death was: 1a Acute subdural haematoma; 2. Atrial Fibrillation (treated with Warfarin)
4	**CIRCUMSTANCES OF THE DEATH** Mrs Long died at John Radcliffe Hospital, Oxford at 0034 hours on 11th July 2018 from injury sustained when she struck her head in her bedroom at her home address on the morning of 10th July 2018, leading to her collapsing later that afternoon.
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 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) Shortly after Mrs Long had been mobilised into an ambulance outside her home address in Hazlemere, near High Wycombe, Buckinghamshire, her condition deteriorated very quickly and her Glasgow Coma Score dropped from 15/15 to 3/15. Her breathing became abnormal and irregular and she became unresponsive. Although the overall intention was to transport to John Radcliffe Hospital as a result

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	of the traumatic head injury, the ambulance crew contacted and requested assistance from the nearest hospital, Wycombe Hospital, due to the concern over Mrs Long's compromised airway. Admission was refused with an instruction to attend the nearest Accident & Emergency Unit so, instead, roadside assistance was provided to the crew near Stokenchurch at the M40 junction from an Enhanced Care Response Unit car whilst en route to John Radcliffe Hospital. Due to the severity of the injury Mrs Long had sustained, exacerbated over the day prior to collapse by her warfarin prescription, the refusal of assistance by Wycombe Hospital (part of Buckinghamshire Healthcare NHS Trust) did not impact upon the outcome in this case. There was, however, a clear difference of opinion between South Central Ambulance Service and Buckinghamshire Healthcare NHS Trust as to the interpretation of the reception policy appropriate to the Cardiac and Stroke Unit at Wycombe. It is understood that informal discussions have been had between both trusts about whether South Central Ambulance Service should or should not be seeking assistance from Wycombe Hospital (where it is the nearest facility) in cases where a compromised airway may lead to cardiac arrest. There is a continuing concern that, in the absence of a clear, formalised understanding, circumstances may arise where either help to stabilise a patient's airway is refused, or a delay occurs as a result of confusion, and a patient dies as a consequence.
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 25th February 2019. 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 family of Joyce Long 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.

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9	**Date: 24th December 2018** **Signed:**  **Crispin Giles Butler, Senior Coroner for Buckinghamshire**

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