REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Secretary of State for Health and Social Care** 2. **North West Ambulance Service** 3. **Cheshire Fire and Rescue** 4. **Cheshire Constabulary**
1	**CORONER** I am Heath Westerman, assistant coroner, for the coroner area of Cheshire
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 11th July 2018 an investigation was commenced into the death of Gladys Esme FURNIVAL (known as Esme FURNIVAL) dob 5th September 1926. The investigation concluded at the end of the inquest on 10th July 2019. The conclusion of the inquest was accidental death. The medical cause of death was 1a multi organ failure, 1b traumatic ischaemic injury to abdomen and 1c fall.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 12.30hrs on Sunday 8th July 2018 Esme Furnival had an unwitnessed fall at her home address a sheltered accommodation in Holmes Chapel, Cheshire, whereby her dressing gown waist cord was caught in the fridge thereby suspending her body with her legs on the floor and her upper body off the floor. Careline monitoring services received a call from Esme at 12.40hrs during which they separately called 999 services at 12.44hrs. That call was given a category 3 response with an expected response time of 90th percentile of 120 minutes. North West Ambulance Service called Careline back at 14.43hrs to inform them that there was significant delay to responding that day due to the volume of calls received. The response was not upgraded to a category 2 but Esme was placed as the top priority within the waiting category 3 responses. The ambulance service arrived at her flat at 17.23hrs and she was transported to Leighton hospital where she sadly died on 9th July 2018. Careline are a remote service and they attempted to contact the manager of the sheltered home and the listed next of kin without success.
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) When the ambulance service is faced with significant delays in circumstances where

	there are no eye's on the ground, there was no provision to utilise the other emergency services to assist in its place or to provide an update to them.
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 9th October 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 following Interested Persons; [redacted] 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	**DATE: 14th August 2019** **SIGNED BY CORONER: Heath Westerman**