REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. East Midlands Ambulance Service;** **2. Chief Coroner;** **3. Chesterfield Royal Hospital;** **4. Royal Derby Hospital; and** **5. Family of the deceased.**
1	**CORONER** I am Emma Serrano, Assistant Coroner, for the coroner area of the Derby and Derbyshire.
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** On the 29th August 2018, I commenced an investigation into the death of Mr Gordon Gillottt. The investigation concluded with a Form B being issued by me. The cause of death after post mortem was: 1a Septicaemia; 1b Necrotic perforated non-reducible left inguinal scrotal bowel hernia; and II Chronic Obstructive Pulmonary Disease and left common iliac aneurysm (operated)
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Gillott presented at Chesterfield Royal Hospital on the 8 August 2018 with a ruptured abdominal aneurism. He was transferred to the Royal Derby Hospital for repair of this. He initially survived the surgery but sadly passed away due to sepsis, secondary to a bowel perforation, not related to the surgery he received. ii) During the course of my investigation I received a letter from the Consultant General and Vascular Surgeon who completed Mr Gillott's surgery. This highlighted Mr Gillott's Transfer to the Royal derby Hospital was delayed substantially. It took over 2 hours for an ambulance to attend for the transfer. Multiple calls were made to the East Midlands Ambulance Service both by emergency staff at the Chesterfield Royal Hospital and the operating Consultant himself. The importance of the rapid transfer was emphasised on each occasion. On one occasion it was stressed that Mr Gillott would die if he was not transferred urgently. iii) Enquiries revealed the initial call requesting transfer was made to the East Midlands Ambulance Service at 05:28. This transfer was assigned at 06:59. Ambulance arrival at Chesterfield Royal Hospital for transfer was at 07:22.

	iv) The Consultant Surgeon has said that whilst he does not believe that the delay contributed to Mr Gillott's death, he has significant concerns that such a delay could be repeated and, under different circumstances, might in fact impact upon patient care, up to and including death of a patient. v) East Midlands Ambulance Service have responded with a report. This states that the call was received at 05:28 and was classified as a Category 2 call. This required conveying a resource to arrive with the patient within 18 minutes. Resourcing issues meant that the ambulance was allocated at 6:59 and arrived at Chesterfield Royal Hospital at 07:22. The report details that the call was processed correctly and that dispatch actions were correctly with staff repeatedly looking for conveyancing resources. vi) The delay in response time was due to resourcing issues.
5	**CORONER'S CONCERNS** During the course of my investigation my inquiries 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. Whilst this delay did not affect Mr Gillott, were this to happen again in the future, there is a risk of future death if urgent transfers are not available to acutely ill patients due to resourcing issues.
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 31 March 2020. 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; 1. The family of the deceased; 2. Chesterfield Royal Hospital; and 3. Royal Derby Hospital. 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	**4 February 2020** **Miss Emma Serrano** **Assistant Coroner** **Derby and Derbyshire Coroners Area**