REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **North West Ambulance Service NHS Trust**
1	**CORONER** I am Nicholas Leslie Rheinberg, senior 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 12th January 2016 an investigation into the death of Joyce Mary Ravenhill aged 84 was commenced. The investigation concluded at the end of the inquest on 23rd August 2016. The conclusion of the inquest was that the deceased who had died as a result of peritonitis, due to intestinal ischaemia, due to arteriosclerosis, had died from Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was taken ill during the afternoon of Christmas Day 2015. She had enduring abdominal pain and during the night vomited frequently and copiously. At 2.29 pm on 26th December 2015 the 111 service run by your Trust was contacted and the symptoms that the deceased was suffering were relayed to the triage nurse who took the call. The triage nurse determined that it was necessary for the deceased to be seen by the Out of Hours doctor. However, since the earliest appointment available at that time was 5.15 p.m., which was outside the mandated maximum waiting time of two hours, the triage nurse indicated that a colleague would telephone back with an earlier appointment. Subsequently a second triage nurse did call back but ignorant of the fact that the only purpose of her call was to arrange an appointment with the Out of Hours doctor, she repeated the triage process and on this occasion determined that the deceased did not need to see the Out of Hours doctor. In the event the deceased remained unwell and after a further failed attempt on 28th December to secure a doctor's appointment through the 111 system obtained an urgent appointment with a local GP on the following day. The GP arranged for the deceased's admission to Macclesfield Hospital where it was discovered that the deceased had an incarcerated femoral hernia which had caused an intestinal obstruction. Although a successful operation was carried out that day to repair the hernia, the deceased died on 2nd January 2016. It is probable that the incarceration of the hernia, together with the intestinal obstruction and the sequela of that condition including vomiting and resulting dehydration played a causal part in the death. It is possible that earlier recognition of the problem and earlier intervention might have prevented the deceased's death.
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 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. – Although a summary of the first triage assessment on 26th December 2015 was available to the second triage nurse, there was no facility / operational policy whereby the simple fact that the deceased needed an urgent doctor's appointment could be effectively communicated by the first triage nurse to the second, all information and communication being automatically electronically generated.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 20th October 2016. 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] the deceased's daughter on behalf of the family and the CQC. 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	**Dated 24th August 2016 SIGNED** **Senior Coroner**