Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO: Will Hancock, Chief Executive Officer, South Central Ambulance Service

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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 15/10/2019 I commenced an investigation into the death of Richard KING, aged 73. The investigation concluded at the end of the inquest on 10th March 2020. The conclusion of the inquest was a Narrative Conclusion as follows:

> *Paramedics were called to the deceased's home on 12th October 2019.. The failure of the paramedic to conduct detailed observations resulted in a lost opportunity to render further medical treatment and he died of a ruptured dissecting abdominal aortic aneurysm.*

His cause of death was:

I a Rupture of Dissecting Thoraco-Abdominal Aortic Aneurysm

II Hypertension

4 CIRCUMSTANCES OF THE DEATH

Mr King complained of a sudden acute pain in his back on 12th October 2019 his home address. His son called the Ambulance Service and a paramedic attended.

The paramedic failed to carry out recognised observations and gave pain killing medication.

The son attended again later the same day found him unresponsive. He was confirmed dead by attending ambulance crew.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

The paramedic who attended the deceased originally did not follow recognise protocols and procedures.

The procedure should be reviewed and if necessary revised to ensure that the seriously ill patient is transferred to hospital for a full assessment.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 30th September 2020. 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:

The family of Mr King

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

Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 05 August 2020