Mrs Sarah Louise Slater
Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive** Yorkshire Ambulance Service Nhs Foundation Trust Trust Headquarters, Springhill Brindley Way, Wakefield 41 Business Park Wakefield WF2 0XQ
1	**CORONER** I am Mrs Sarah Louise Slater, Assistant Coroner for South Yorkshire (East District)
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/part/7/made
3	**INVESTIGATION and INQUEST** On 01/09/2016 I commenced an investigation into the death of Barry Stuart Hodges, 69 . The investigation concluded at the end of the inquest on 20 April 2017. The conclusion of the inquest was a narrative conclusion. On the 23rd August 2016, Mr Hodges collapsed at Doncaster Tennis Club. An ambulance was called and coded Amber with a 19 minute response time but did not attend until 41 minutes after the initial call was made. On arrival, the paramedics found Mr Hodges to be in cardiac arrest, he was assessed and transferred to Doncaster Royal Infirmary where he was pronounced deceased. It is not possible to ascertain if the outcome would have been different if the ambulance had arrived sooner, although with a cardiac arrest any delay in treatment leads to a poorer prognosis.
4	**CIRCUMSTANCES OF THE DEATH** Mr Hodges appeared to be a fit 69 year old man who regularly played tennis. On the 23rd August 2016 Mr Hodges complained of chest pains and collapsed at the Tennis Club. An ambulance was called at 19:12 hours and there were two resources available at this time. These were not allocated due to the incident being uncoded. At 19:14 hours, Mr Hodges was coded amber with a response time of 19 minutes, but the despatcher did not review the resources available at the time of coding or within 2 minutes as set down in the protocol. No resources were allocated but potentially two were available. The protocol also states that a review of resources should take place every 10 minutes following coding but this did not occur. The first review of resources occurred at 19:28 hours when a resource was available but not allocated, and again at 19:35 hours when a resource was available but again not allocated. Mr Hodges' condition deteriorated and a second call was made to Yorkshire Ambulance Service at 19:46 hours. At 19:47 hours, Mr Hodges was recoded as red and resources were allocated arriving at the scene at 19:53 hours. Bystander CPR was taking place when paramedics arrived at 19:53 hours. Mr Hodges was transferred to Doncaster Royal Infirmary but he was declared deceased a short time after arrival.

	The cause of death is:- 1a) Left ventricular failure; 1b) Ischaemic heart disease; 1c) Coronary artery atheroma.
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) Protocols for ambulance dispatch and review of resources were not adhered to and there appeared to be an absence of any system to "safety net" should an individual operative not manually refresh and look at the system. (2) A lack of knowledge/training/understanding of the protocols that 4 resources were available at different times but none were utilised. (3) Time scales were breached without further action ie. escalation to Senior Management, Clinicians or allocation of resources.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Chief Executive 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 19th June /2017. 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] and [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	Dated 24 April 2017 Signature Assistant Coroner for South Yorkshire (East District)

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