REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Clinical Director** **East of England Ambulance Service** **NHS Trust** **Headquarters** **Melbourn Ambulance Station** **Whiting Way** **Melbourn** **Cambridgeshire** **SG8 6NA**
1	**CORONER** I am YVONNE BLAKE, Area Coroner, for the coroner area of NORFOLK
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 30 January 2019 I commenced an investigation into the death of Christopher Williams aged 77 years. The investigation concluded at the end of the inquest on 22 May 2019. The conclusion of the inquest was concluded with a narrative conclusion and the medical cause of death given as: 1a) Multi-Organ Failure 1b) Sepsis 1c) Infected Post-Op Wound (Staph Aureus) 2 Obesity, Immobility and Hypertension.
4	**CIRCUMSTANCES OF THE DEATH** Mr Williams underwent a day procedure on 19 January 2019 to remove a screw from a previous foot surgery because of infection developing around the site. He had a popliteal nerve block and the procedure was uneventful. Two days later on the 22 January 2019 he developed severe pain in that leg making it impossible for him to weight bear. He called the surgeons secretary and was advised to call his GP which he did. He had also developed paraesthesia to both legs and worsening back pain. His GP attended and requested an urgent ambulance since she was concerned about cauda equina. She also arranged for him to be admitted directly to the ward at the NNUH. She called the ambulance service at 14:17hrs, she was told it may take up to four hours, a pick-up time of 15:17 hrs was entered. At 15:20 hrs the Trust called the patient back and was told that his condition was worsening, however the call handler did not escalate this information within the control centre and thus no-one else was aware. It is understood that the call handler also used an incorrect algorithm (haemorrhage) which led to the wrong questions being used. A further welfare call was made at 17:40hrs but no answer

	received so this was escalated to the Duty Officer who subsequently upgraded the call to a grade 3. At 19:41 hrs [redacted] made a 999-call describing Mr Williams not being alert and having difficulty in breathing and the call was upgraded to a category 1. A RRV and DSA were dispatched at 19:45hrs and arrived on scene at 19:58 and 20:01hrs respectively. Mr Williams was conveyed to the NNUH arriving at 20:59hrs. He was then kept in the ambulance until 23:56 hrs when he finally entered the Emergency Department. He was admitted to a surgical ward after preliminary investigations by the Emergency Department and orthopaedic doctors with a working diagnosis of possible pulmonary embolus. His condition worsened rapidly on morning of the 23 January 2019 with hypoxia, acute kidney injury and low consciousness. The opinion was that he had sepsis with worsening heart failure. He was admitted to High Dependency Unit but despite intensive treatment he died on the 26 January 2019.
5	**CORONER'S CONCERNS** During 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) The amount of time taken for the ambulance to arrive which was markedly outside the Trust's guidelines. (2) The failure by the call handler to both escalate Mr Williams worsening condition and her incorrect use of the haemorrhage algorithm. (3) When the ambulance transported Mr Williams to the NNUH he was kept on board the vehicle awaiting a space in the Emergency Department, despite a bed already arranged several hours before by the GP. This information was unknown to the crew and resulted in several hours delay in Mr Williams being investigated and treated which may have contributed to his death by sepsis. The Trust's Business Continuity Manager was unaware until the inquest that the call handler had erred in failing to escalate and in using the wrong algorithm. He gave evidence that the Trust does not have an algorithm dealing with neurological deficit only a question asking if the patient is conscious. Given that Mr Williams had paraesthesia to both legs and the GP's concerns about cauda equina this would seem to be a potentially dangerous gap in the Trust's triaging system, placing patients at risk. In evidence the reasons given for the call handlers failure was that they did not know why she failed to escalate Mr Williams' worsening condition and why she used the wrong algorithm and that the supplier of their IT software (the triage system), were reluctant to add a neurological algorithm, the reason for this is unclear. When asked the manager accepted that as the customer surely (the trust) could state that a neurological algorithm was necessary but merely that the supplier was reluctant. It is unknown why the paramedic crew were unaware of the arranged admission bed and the manager accepted in evidence that he had not made any enquiries about this, prior to inquest. Again, this failure in communication is one which I feel places other patients at risk of death and is unacceptable. This is not an isolated incident (death) and it appears that there are systemic failures within your organisation which should be addressed.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and the East of England Ambulance service NHS Trust 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 26 July 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] – Wife I have also sent it to [redacted] – Orthopaedic Surgeon who may find it useful or of interest. 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	**31 May 2019** ..... **[SIGNED BY CORONER]** **Norfolk Coroner Service** **69-75 Thorpe Road** **Norwich NR1 1UA**