Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive East of England Ambulance Service NHS Trust Whiting Way Melbourn Cambridgeshire SG8 6EN
1	**CORONER** I am JACQUELINE LAKE, senior 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 04 March 2022 I commenced an investigation into the death of Barbara HOLLIS aged 71. The investigation concluded at the end of the inquest on 24 August 2022. The medical cause of death was: 1a Fat Embolism 1b Left Total Knee Replacement Operation 2 Acute Myocardial Infarction The conclusion of the inquest was that: Mrs Hollis died from a rare but recognised risk of an elective operation
4	**CIRCUMSTANCES OF THE DEATH** Mrs Hollis underwent a total left knee replacement operation on 22 February 2022. The surgery was uneventful with no complications. After her return to the ward Mrs Hollis became restless and confused. Following a review of her deteriorating condition the decision was made to transfer her to the High Dependency Unit at the Norfolk and Norwich University Hospital. Arrangements were made for the transfer and the ambulance service was called at 19.51 hours and were told that immediate clinical intervention was needed. The agreed hospital to hospital transfer pathway was not followed. A two hour delay in ambulance attendance was notified. Mrs Hollis continued to deteriorate and the ambulance service was telephoned again at 21.17 hours. The ambulance attended at 21.27 hours and Mrs Hollis was taken to the High Dependency Unit at the Norfolk and Norwich University Hospital. Her condition continued to deteriorate

	and Mrs Hollis died in the early hours of the 23 February 2022.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. EEAST were telephoned at 19.51 hours and the caller said that immediate intervention was needed. The incorrect pathway was then followed and it is understood action has been taken in this respect. 2. The call was coded as a Category 2 response, with the aim of responding within 40 minutes and with the average response time of 18 minutes 3. At 21.17 hours a second telephone call was made to EEAST. An ambulance was on scene at 21.27 hours 4. There were no emergency ambulances to respond to the initial 999 call due to high demand on the service 5. It is accepted that EEAST have taken several steps following the increase in call demand and subsequent delays in responding to patients. However, evidence was heard that it will take up to a year to see if these steps are effective. In the meantime, there is concern that future deaths will occur
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 October 20, 2022. 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] Spire Healthcare I have also sent it to

	Department of Health Care Quality Commission (CQC) HSIB Healthwatch Norfolk NHS England & NHS Improvement who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 07/10/2022**  **Jacqueline LAKE** **Senior Coroner for** **Norfolk**