REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE 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 17 December 2021, I commenced an investigation into the death of Christina Avis RUSE aged 79. The investigation concluded at the end of the inquest on 22 August 2022. The medical cause of death was: 1a Multi-organ Dysfunction 1b) Hypovolaemic Shock 1c) Total Hip Replacement (Left) 14/12/21 1d) 2 Atrial Fibrillation, Ischaemic Heart Disease, Hypertension, Stroke, Myelofibrosis, Ex-Smoker, Chronic Kidney Disease. The conclusion of the inquest was: Misadventure.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Ruse was admitted to the Spire Hospital on 14 December 2021 and underwent a total left hip replacement. Her condition deteriorated and observations were commenced at five minute intervals. Mrs Ruse was reviewed and on further deterioration in her condition it was decided to transfer Mrs Ruse to the High Dependency Unit, Norfolk and Norwich University Hospital. On arrival of the ambulance Mrs Ruse was undergoing a further investigatory procedure. On this being completed Mrs Ruse was taken to the Norfolk and Norwich University Hospital. Her condition continued to deteriorate and Mrs Ruse died on 15 December 2021.

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: 1.EEAST were telephoned at 19.30 hours to request an ambulance to transport Mrs Ruse to the High Dependency Unit. This was coded as a Category 2 response, with the aim of responding within 40 minutes and with the average time of 18 minutes. 2. There were no emergency ambulances available to assign to this call due to high call demand. 3. An ambulance did not become available until 20.54 hours and arrived on scene at 20.57 hours, by which time Mrs Ruse had deteriorated further and had been taken back into theatre. EEAST staff did wait (exceeding the period of their shift) and Mrs Ruse was taken to the High Dependency Unit at 22.42 hours. 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: 26/08/2022**  **Jacqueline LAKE** **Senior Coroner for** **Norfolk**