REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Secretary of State for Health and Social Care:** **The Rt Hon Steve Barclay MP** **The Department of Health and Social Care** **The Norfolk and Waveney Integrated Care Board**
1	**CORONER** I am Catherine Wood, Assistant 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 the 30th May 2022 an inquest was opened into the death of Kyriacos Athanais. At the inquest hearing on 4th January 2023, I concluded with the short form conclusion of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Kyriacos Athanasis was an 88-year-old man who had a past medical history of asthma, chronic kidney disease stage 3, hypertension, orthostatic hypotension, type 2 diabetes mellitus and ulcerative colitis. At the beginning of 2022 he was becoming more frail and suffering from falls leading to hospitalisations. He fell down some stairs at home at some point on 16th May 2022 and was subsequently taken to the James Paget hospital arriving at around 21.30 on 17th May 2022. After some delay in offloading him from an ambulance he was diagnosed as suffering from an unstable cervical spine fracture. There was a delay in seeking senior clinical advice which in turn led to a delay in being able to sit him upright. During this period, he developed pneumonia which was in part due to aspiration whilst nursed immobile and flat in conjunction with his hiatus hernia, influenza A and chronic obstructive pulmonary disease. He was treated with intravenous antibiotics and oxygen therapy but deteriorated and died as a consequence of his multifactorial pneumonia predominately due to the consequences of his fall on a background of frailty and type 2 diabetes mellitus.
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 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) Evidence given at the inquest revealed that there was a delay in Mr. Athanasis being transferred from the ambulance into the emergency department at the James Paget hospital as they had no space for him to be transferred into.

	(2) As there had been known delays in obtaining space in the emergency department at the Trust senior clinicians undertook a safety check of those patients left in ambulances to assess the urgency and need for a trolley or bed. (3) In this instance the mechanism to undertake a safety check was not sufficient to reveal the extent of the injuries Mr. Athanasis had sustained, and this meant there was a delay in diagnosing him with his unstable cervical fracture. This delay in conjunction with other issues more than minimally or trivially contributed to his death. (4) The Emergency department staff gave evidence that they regularly have too many patients in the department and cannot find space to safely allow ambulances to transfer patients into their care and then leave. The staff at the Trust indicated that they did not consider that locally there were any further steps they could take and gave evidence this was a more complex problem, predominately due to the Trust's inability to discharge patients who are medically fit to be discharged and occupying much needed beds. This in turn means that they are unable to move patients from the emergency department to beds in the hospital in a timely manner which leads to them not having capacity to admit patients brought in by ambulances. This clearly means that ambulances are delayed and in turn are unable to attend other emergencies in a timely manner. (5) Significant local steps have been taken to reduce the risks to patients, but the department is functioning well over their capacity (at the time of the hearing the Trust had 75 patients in a department designed for 40). There are clear risks of future deaths for patients waiting for an ambulance as well as to patients whose diagnosis and treatment is delayed due to limited intervention being available in the back of an ambulance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 3 March 2023. 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] The James Paget University Hospital NHS Foundation Trust. 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 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	**6 January 2022**  **Catherine Wood** **Assistant Coroner** **Norfolk**