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:** **The Secretary of State for Health and Social Care:** **The Rt Hon Steve Barclay MP** **The Department of Health and Social Care**
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 07 June 2022 I commenced an investigation into the death of Lyn Mary BRIND aged 61. The investigation concluded at the end of the inquest on 05 January 2023. **The medical cause of death was:** 1a) Congestive Cardiac Failure 1b) Ischaemic and Hypertensive Heart Disease 1c) Coronary Artery Atherosclerosis and Morbid Obesity 2) Diabetes Mellitus **The conclusion of the inquest was:** Mrs Brind died from cardiac failure. Her condition was not diagnosed nor treated in a timely fashion.
4	**CIRCUMSTANCES OF THE DEATH** On 24 May 2022, Mrs Brind went to see her GP and was taken to Queen Elizabeth Hospital arriving at 13.05 hours. The Emergency Department was busy and Mrs Brind remained on the ambulance. Physiological observations were undertaken at 12.50, 13.24 and 13.53 which showed an elevated NEWS2 score. Mrs Brind required increasing oxygen which was not escalated to the Ambulance Navigator at the hospital, no further physiological observations were undertaken and no ECG was undertaken. Mrs Brind was taken to the ward at 17.30 hours, when she became agitated and short of breath. Advanced life support was put into place but Mrs Brind's condition continued to deteriorate and she died at 17.52 hours.
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) Evidence was heard that there was a delay in Mrs Brind being transferred from the ambulance to the Emergency Department of the Queen Elizabeth Hospital as there was no space in the hospital 2) As delays are a reoccurring problem, checks are made by paramedics and Hospital clinicians on patients while they wait in ambulances for transfer into the hospital to assist in prioritising the need for transfer. 3) In the case of Mrs Brind, physiological observations were not undertaken regularly in accordance with East of England Ambulance Service Trust (EEAST) Guidance and when they were taken, her high NEWS2 score was not escalated to the Hospital Ambulance Navigator who assesses priority for beds in the hospital. 4) Further Mrs Brind was not assessed by a Senior Doctor from the Hospital within an hour, in accordance with Hospital protocol 5) I am satisfied that steps have been taken by both EEAST and the Hospital in respect of these matters and do not make a report in respect of either of these matters 6) Evidence was heard that there are regularly too many patients in the Emergency Department and so ambulances cannot safely transfer patients into the Emergency Department. The EEAST is working with the Hospital (along with other hospitals in the area) to find ways to deal with this problem and methods are in place to try to alleviate the consequences of these delays. 7) However, it was heard that this is a much wider and more complex problem, in that the Hospital is unable to discharge patients who are medically fit to be discharged and they remain occupying much needed beds. This in turn means patients cannot be moved from the Emergency Department into the hospital wards, and patients remain waiting in ambulances. This in turn causes delays in ambulances being returned to normal duty and being able to attend to emergencies in the community. 8) Evidence was heard that at the time of Mrs Brind's death, approximately 7 ambulances were waiting to transfer patients into the Emergency Department, Queen Elizabeth Hospital. At the time of the inquest, this had risen to 17 ambulances commonly waiting to transfer patients from the ambulance into the Emergency Department. 7) Further at the time of the inquest there were approximately 140 beds at the Queen Elizabeth Hospital occupied by patients who were medically fit to be discharged, but beds could not be found in the community
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 March 13, 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] Queen Elizabeth Hospital East of England Ambulance Service NHS Trust (EEAST)

	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: 18/01/2023** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH