IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Keith Nielsen
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Officer South East Coast Ambulance Service (SECAMBS) 4 Gatwick Road Crawley Sussex RH10 9BG Rt. Hon. Steve Barclay Secretary of State for Health and Social Care 39 Victoria Street London SW1H OEU
2	**CORONER** Miss Anna Crawford, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

4	**INQUEST** An investigation into Mr Nielsen's death was commenced on 30 March 2022 and an inquest was opened on 5 April 2022. The inquest resumed on 4 April 2023 and concluded on 13 April 2023. The medical cause of Mr Nielsen's death was: 1a. Traumatic Brain Injury Causing Bi-Frontal Haemorrhagic Contusions 2. Anti-Coagulant Medication (Warfarin) due to previous Aortic Valve Replacement The inquest concluded with a narrative conclusion as follows: 'Mr Nielsen was a 73 year old man who was prescribed the anti-coagulant medication Warfarin. On 20 March 2022 he sustained a head injury due to an unwitnessed fall at his home address. On the morning of 22 March 2022 Mr Nielsen was admitted to East Surrey Hospital and on 23 March 2022 he died at the hospital due to a head injury contributed to by his anti-coagulant medication which exacerbated the bleeding. At 05:33 on 21 March 2022 Mr Nielsen had made a 999 call reporting that he had fallen over and hit his head. South East Coast Ambulance Service (SECAMBS) did not send an ambulance due to a lack of available resources and Mr Nielsen was advised to make his own way to hospital. The 999 call was then closed with a 'no send' disposition. However, Mr Nielsen did not make his way to hospital. Mr Nielsen's 999 call was not suitable for a 'no send' disposition because he was on his own with a suspected head injury and had reported a loss of consciousness for a significant period of time in the context of being on warfarin. Further, he had given no clear indication that he was going to make his own way to hospital. In the event that an ambulance had attended to take Mr Nielsen to hospital on 21 March 2022 he would have survived.'

5	**CIRCUMSTANCES OF THE DEATH** On the morning of 21 March 2022 Mr Nielsen found himself on the floor at his home address and was unable to remember the previous twelve hours. At 05:33 Mr Nielsen called 999 and at some point that morning he also made an online request for a routine GP appointment. During the 999 call Mr Nielsen reported that he had fallen over and hit his head and could not remember the last twelve hours. He also reported that he took Warfarin. The call handler triaged the call following the NHS pathway which resulted in a Category 3 ambulance response with a target response time of two hours. However, Mr Nielsen was advised to make his own way to hospital and the call was closed as a no send disposition. At 16:18 a GP at Medwyn GP surgery contacted Mr Nielsen by phone in response to his earlier online request for a routine appointment. The GP was not made aware of the fall or the head injury but given that Mr Nielsen was confused during the call and was on Warfarin he asked his receptionist to call an ambulance. At 17:37 a receptionist called and requested an ambulance within two hours. However, an ambulance did not attend until 07:22 the following morning at which time Mr Nielsen was found to be unresponsive. He was taken to East Surrey Hospital, where he was diagnosed with a traumatic brain injury and he died at the hospital on 23 March 2022. On 21 March 2022 SECAMBS was operating at Level 4 of its Surge Management Plan, meaning that demand for the service was significantly outstripping available resources and the service was not capable of responding to calls within target timeframes. The court heard evidence that SECMABS operates a no send policy during Level 4 of its Surge Management Plan whereby Category 3 patients are asked to make their own way to hospital. However, if they are unable to make their own way to hospital - or they refuse to do so - the call is subject to a clinical review and a decision is taken as to whether an ambulance should be sent out to the patient. During his 999 call, Mr Nielsen reported that he was alone, had hit his head and could not remember the last twelve hours. He did not agree to make his own way to hospital.

	Accordingly, the court found that a clinical review should have taken place which would have resulted in a category 3 ambulance being assigned to Mr Nielsen. In the event that a category 3 ambulance had been so assigned Mr Nielsen would have survived. Additionally, the court found that there was a significant delay in dispatching an ambulance following the GP surgery's call to request an ambulance for Mr Nielsen, which was due to SECAMBS being in Level 4 of its Surge Management Plan. Whilst the length of that delay is clearly a matter of concern, it did not materially contribute to Mr Nielsen's death. The court heard evidence from [redacted], Operating Unit Manager at SECAMBS, that the organisation is regularly operating at Level 4 of the Surge Management Plan. He gave evidence that the reasons were multi-factorial and, in particular, he highlighted insufficient staff being available to cover the required operational hours and lengthy delays in hospital handovers leading to a loss of operational hours. .

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: There is a risk of a future reoccurrence of the situation which arose on 21 March 2022 given that SECAMBS is regularly operating at Stage 4 of its Surge Management Plan, meaning that demand for the service is significantly outstripping available resources and the service is not capable of responding to calls within target timeframes.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. [redacted] 3. [redacted]
10	**Signed:** **ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 26th day of June 2023**