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 Right Honourable Steve Barclay MP** **Secretary of State for Health and Social Care** **House of Commons** **London** **SW1A 0AA**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 11 November 2022 I commenced an investigation into the death of Christopher Ivan HART aged 50. The investigation concluded at the end of the inquest on 27 October 2023. The conclusion of the inquest was that: Narrative Conclusion The medical cause of death was confirmed as: 1a Coronary Artery Atherosclerosis 1b 1c
4	**CIRCUMSTANCES OF THE DEATH** On the 25th October 2022 Christopher Hart was declared deceased at his home address of 30 Old Barrack Lane, Woodbridge in Suffolk. Christopher had become unwell at approximately 01:00 on 25th October 2022, and an ambulance was requested via a 999 call. Due to high service demand, and ambulances waiting to off-load their patients at the local hospitals, no ambulance was immediately available. The 999 call had been coded at Category 2 , with an average expected response time of 40 minutes, and a target attendance time of 18 minutes. At approximately 09:30 a family member visited Christopher's home, finding him unresponsive and not breathing on the lounge floor. East of England Ambulance Service attended, but Christopher could not be resuscitated. His death was recognised at 09:35 on the 25th October 2023. A subsequent post-mortem examination identified that cardiac condition was responsible for Christopher's death.

	The delay in an ambulance attending meant that potentially life saving treatment could not be given, so that delay directly contributed to Christopher's death.
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) Evidence heard from a Patient Safety Officer from the East of England Ambulance Service identified that, despite previous measures put in place, there are continuing and regular instances of non-availability of ambulances occurring in Suffolk and the wider East of England region. These periods of non-availability (in this case of over 8 ½ hours) fall far short of the target attendance times set by the East of England Ambulance Trust itself. Expert evidence from a Consultant Interventional Cardiologist, whose unit treats up to three thousand patients with serious cardiac issues such as Christopher's each year, identified that had an ambulance for Christopher arrived within the target time, the drugs he could have been given by ambulance personnel, and his early transport to hospital, would on a balance of probabilities have saved his life. I am therefore concerned that the continuing lack of sufficient ambulance resource in Suffolk will lead to future loss of life.
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 January 04, 2024. 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] I have also sent it to **East of England Ambulance Service NHS Trust** 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	**Dated: 09/11/2023**  **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**