## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 The Right Honourable Steve Barclay MP**<br>**Secretary of State for Health and Social Care**<br>**House of Commons**<br>**London**<br>**SW1A 0AA** |
| **1** | **CORONER**<br><br>I am Nigel PARSLEY, HM Senior Coroner for the coroner area of Suffolk |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 16 December 2022 I commenced an investigation into the death of Gina Marie BYWATER aged 36. The investigation concluded at the end of the inquest on 01 November 2023. The conclusion of the inquest was that:<br><br>**Narrative Conclusion - Natural causes due to an untreated cardiac condition, the death being contributed to by a delay in attendance of an ambulance, that delay being caused by extreme resource pressures on the ambulance service at the time.**<br><br>The medical cause of death was confirmed as:<br><br>**1a Acute Myocardial Infarction**<br>**1b**<br>**1c**<br>**2 Fatty Liver, Pancreatic Cyst and Fibrosis** |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>**On the 13th December 2022 Gina Bywater was declared deceased at her home address [redacted] in Suffolk.**<br><br>**Gina had become unwell at approximately 22:00 on 12th December 2022, with vomiting and shortness of breath.**<br><br>**An ambulance was requested via a 999 call at 00:01 hours on the 13th December 2022, but due to high service demand, and ambulances waiting to off-load their patients at the local hospitals, no ambulance was immediately available.**<br><br>**A second 999 call was made at 01:08 stating that Gina was now suffering chest pains, and a third was made at 04:07, but again no resources were available.**<br><br>**All of the 999 calls had been coded at Category 2 , with an average expected response time of 40 minutes, and a target attendance time of 18 minutes.** |

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| | **The East of England Ambulance service made a welfare call at 09:36, and during this call it was identified that Gina had gone into cardiac arrest.**<br><br>**A Category 1 response was therefore initiated and an ambulance arrived with Gina at 09:45.**<br>**A subsequent post-mortem examination identified that she had died as the result of a heart attack.**<br><br>**The delay in an ambulance attending meant that lifesaving treatment could not be given, so that delay directly contributed to Gina's death.** |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>**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.**<br><br>**These periods of non-availability (in this case nearly 10 hours) fall far short of the target attendance times set by the East of England Ambulance Trust itself.**<br><br>**Expert evidence from a Consultant Interventional Cardiologist, whose unit treats up to three thousand patients with serious cardiac issues such as Gina's each year, identified that had an ambulance for Gina arrived within the target time, the drugs she could have been given by ambulance personnel, and her early transport to hospital, would on a balance of probabilities have saved her life.**<br><br>**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**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by January 03, 2024. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>**1. Gina's next of kin.**<br>**2. East of England Ambulance Service**<br><br>I am also under a duty to send the Chief Coroner a copy of your response. |

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| | 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. |
| **9** | **Dated: 07/11/2023**<br><br>  <br><br>**Nigel PARSLEY**<br>**HM Senior Coroner for**<br>**Suffolk** |