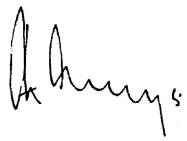
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Chief Executive of East of England Ambulance Service** **2 [redacted], Chief Executive Officer, Royal College of Emergency Medicine** **3 [redacted], Managing Director, Association of Ambulance Chief Executives** **4 [redacted], National Medical Director, NHS England**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 09 January 2023 I commenced an investigation into the death of Michael John VINCENT aged 79. The investigation concluded at the end of the inquest on 25 May 2023. The conclusion of the inquest was that: Mr Michael John Vincent died at the Luton and Dunstable Hospital on the 20th December 2022. He was 79 years old. He had fallen the morning before, at home, and had remained on the floor until admittance to the ED at approximately 05:32 on the 20th December 2022. He had made a first call to the East of England Ambulance Service at around 7:29 pm on the 19th December 2022. The call was allocated a C2 category which aims to have an urgent response within an 18 minute time frame. The EEAS was extremely busy that night with previously unseen levels of C2 allocations of ambulances. In addition, the hospitals in the area were queuing ambulances outside ED's because they were unable to offload patients and then proceed to other calls. That combination meant that despite being allocated an urgent response time Mr Vincent was effectively left on the floor for a very prolonged time. Ultimately he had a cardiac arrest at home and an ambulance attended promptly. He was resuscitated but the "down time" was prolonged. He died as a result of a combination of an undiagnosed bronchopneumonia complicated by severe coronary artery disease and a long lie. On the balance of probabilities it is likely that had he been admitted at the time of the first call he would not have died at the time he did.
4	**CIRCUMSTANCES OF THE DEATH** Mr Michael John Vincent died at the Luton and Dunstable Hospital on the 20th December 2022. He was 79 years old. He had fallen the morning before, at home, and had remained on the floor until admittance to the ED at approximately 05:32 on the 20th December 2022. He had made a first call to the East of England Ambulance Service at around 7:29 pm on the 19th December 2022. The call was allocated a C2 category which aims to have an urgent response within an 18 minute time frame. The EEAS was extremely busy that night with previously unseen levels of C2 allocations of ambulances. In addition, the hospitals in the area were queuing ambulances outside ED's because they were unable to offload patients and then proceed to other calls. That combination meant that despite being allocated an urgent response time Mr Vincent was effectively left on the floor for a very

	prolonged time. Ultimately he had a cardiac arrest at home and an ambulance attended promptly. He was resuscitated but the "down time" was prolonged. He died as a result of a combination of an undiagnosed bronchopneumonia complicated by severe coronary artery disease and a long lie. On the balance of probabilities it is likely that had he been admitted at the time of the first call he would not have died at the time he did.
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) Mr Vincent had fallen many hours prior to making his first call to the ambulance service. There then followed a further ten hour delay, during which time he had a cardiac arrest, before he was admitted to the Emergency Department. He had been allocated an appropriate response time, expected within 18 minutes at 1929 on the 19th December 2022. For the reasons given in the circumstances above, that target was missed by an enormous margin. There is a strong possibility, even arguably a probability that another frail, elderly individual, will have the same experience. Long lie after a fall, especially in the elderly often results in a terminal kidney injury and death. Consideration should be given to review of how these types of emergency call are managed and thereafter monitored.
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 02, 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 I have also sent it to [redacted] 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: 07/11/2023**  **Sean CUMMINGS** **Assistant Coroner for** **Bedfordshire and Luton Coroner Service**