	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU,** **2. The West Yorkshire Integrated Care Board, White Rose House, West Parade, Wakefield, WF1 1LT.**
1	**CORONER** I am **Katy Dickinson** His Majesty's Assistant Coroner for South Yorkshire West.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 25 May 2023 I commenced an investigation into the death of Shaun PARKS. The investigation concluded at the end of the inquest on 15 December 2023. The conclusion of the inquest was that Mr Parks died on 13 December 2022 at the Northern General Hospital in Sheffield, there was a significant delay in Mr Parks receiving treatment and this may have affected the outcome. His medical cause of death was recorded as: 1a Myocardial infarction (stented) 1b Ischaemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** Mr Parks attended Doncaster Royal Infirmary's Emergency Department on 12 December 2022 at roughly midnight, Mr Park's waited in the emergency department for approximately 1-1.30 hours until an ECG was carried out and showed Mr Parks to be suffering a heart attack. Mr Parks was moved to the resuscitation area of the department and an interfacility transfer request to the Northern General Hospital's primary percutaneous coronary intervention (PPCI) centre was made by a nurse at the hospital to Yorkshire Ambulance Service (YAS). It was confirmed by YAS that the category 2 blue light ambulance was booked at 3.06am on 13 December 2022, the ambulance should have taken at the latest 40 minutes to arrive, YAS confirmed the ambulance was categorised correctly as a category 2. The ambulance arrived at Doncaster Royal Infirmary at 06.29 hours and left scene to transfer to Sheffield's Northern General

	Hospital's PPCI 06.44 and arrived at 07.15. Mr Parks deteriorated during his time at Doncaster Royal Infirmary and his procedure at Sheffield's PPCI unit commenced at 08.45. Mr Parks sadly died during the procedure at 10.17. There was a delay in the ambulance arriving to collect Mr Parks of 3 hours 18 minutes and 41 seconds.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) The ambulance response time of 3 hours and 18 minutes has likely affected the outcome. (2) There were insufficient Emergency Medical Dispatcher's available to meet the forecasted demand. Staffing at YAS was below the requirement to meet the expected demand. (3) There was a significant delay in offloading patients at hospitals, which tied up resources and meant they were unable to respond to emergency calls.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 14 February 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 - Mr Park's family. - Yorkshire Ambulance Service, Brindley Way, Wakefield, WF2 0XG. - Doncaster Royal Infirmary, Thorne Rd, Doncaster DN2 5LT. - Sheffield Teaching Hospitals, Herries Road, Sheffield S5 7AU. I may also send a copy of your response to any person 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	20 December 2023 Signature  Katy Dickinson H.M Assistant Coroner for South Yorkshire West.