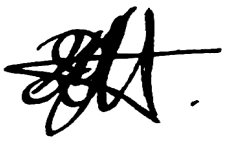
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Rt Hon Victoria Atkins, Secretary of State for Health and Social Care** **2 [redacted], Chief Executive of NHS England** **3 [redacted], Chief Executive of the East of England Ambulance Service**
1	**CORONER** I am Darren STEWART OBE, HM Area 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 20 December 2022 I commenced an investigation into the death of Dennis John William KING aged 84. The investigation concluded at the end of the inquest on 29 November 2023. The inquest was heard without a Jury. I returned the following narrative conclusion: Dennis John William KING died as a result of recognised complications following necessary, life-saving emergency treatment for a myocardial infarction. The medical cause of death was confirmed as: 1a Multi Organ Failure 1b Post myocardial infarction left ventricular free wall rupture (operated on)
4	**CIRCUMSTANCES OF THE DEATH** On the evening of 9th December 2022, Dennis John William KING suffered sudden chest pain which extended down his arm. At 22.51PM Mr. KING's wife called 999 and spoke with an ambulance service call handler. Following triage of the call, the response to Mr. KING's call was graded as a Category 3 (a potentially urgent condition which is not life threatening with a target response of 120 minutes). This call was subsequently re-graded following review in the call centre at 23.18PM to a Category 2 (a potentially serious condition requiring rapid assessment, urgent on scene intervention or transport to hospital, with a response within 40 minutes and a target of 18 minutes). At 23.53PM Mrs. KING called again to enquire after the estimated time of arrival for the ambulance and was advised that due to high demand in the West Suffolk area that evening, the waiting time for an ambulance could be as long as six hours. On receiving this information Mr. and Mrs. KING decided to make their own way to the West Suffolk Hospital arriving there at 00.58AM on the 10th December 2022. The ambulance service were advised and the response stood down. Within 40 minutes of arrival Mr. KING had been diagnosed as suffering an ST segment elevation myocardial infarction (STEMI) and arrangements made for him to be received as a patient at the regional specialist centre at the Royal Papworth Hospital for an urgent

	angioplasty procedure to be performed. The time was 01.44AM, 10th December 2022. Mr. KING's condition at this point was stabilised and he was being closely monitored in a resuscitation room. Treating clinicians assessed his condition as necessitating an urgent transfer to the Royal Papworth and for the angioplasty procedure to be conducted forthwith. The ambulance call centre was contacted by the hospital emergency department at 01.37AM with a request for an urgent transfer to the Royal Papworth. Emergency department staff were advised that there would be a 5 hour delay for an ambulance to attend. The call from the hospital emergency department to the ambulance service was graded by the ambulance call handler as a category 2 response. When the response timing was challenged the emergency department matron was advised that the hospital was a place of safety. The ambulance call handler assessment did not seem to take into account the clinical assessment of accident and emergency department staff who, in consultation with the regional cardiac intervention hospital, had determined Mr. KING's further treatment at the regional cardiac centre was a matter of urgency. An ambulance subsequently arrived at West Suffolk Hospital Accident and Emergency Department at 04.36AM and then transferred Mr. KING to the Royal Papworth Hospital, arriving at 05.56AM on the 10th December 2022. Mr. KING underwent treatment for what was identified as an occluded left anterior descending artery. The procedure was completed without incident and Mr. KING was placed on a cardiac ward. About 1 hour after the procedure, Mr. KING's condition deteriorated and he suffered a left ventricular wall rupture, a recognised complication of either the myocardial infarction he had suffered or the surgical procedure to correct the occluded artery, or both. Mr. KING received emergency surgery to repair the rupture by way of a patch which was successful. However, Mr. KING's condition deteriorated and he died on the 13th December 2022.
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: a. Availability of ambulances to carry out transfers in a timely manner, in urgent cases, between NHS Hospitals and in responding to 999 and 111 calls in the community. b. Confusion as between ambulance and hospital staff and a lack of clarity in the purpose of and process for the categorisation of transfers (particularly in urgent situations) between NHS hospitals. c. The suitability of the NHS approach to centralising exigent care in regional centres (such as the Royal Papworth Hospital for cardiac conditions) if the means to deliver such an approach are inadequate. d. Adequacy of the action plan provided to the court in addressing the concern at (a) above and that of ambulance attendances to 999 and 111 calls; the plan is generalised, lacking detail and any means of measurement of progress. Evidence received at Inquest identified waits for ambulance attendance of between 5-6 hours on the evening of 9th/10th December 2022. This, in circumstances where the call relating to Mr. KING had been categorised as a category 2 response. In Mr. KING's case he was exhibiting symptoms of having suffered/was suffering a heart attack. In Mr. KING's case he had arrived at hospital been triaged, assessed and arrangements for urgent lifesaving care made by competent emergency clinicians in conjunction with experts from the regional cardiac unit. This included the requirement for an urgent transfer to the regional cardiac centre. A request for an emergency transfer from West Suffolk Hospital to The Royal Papworth Hospital was subject to further computer algorithm-based triage by the ambulance service. This resulted in a several hour delay to Mr. KING's transfer, notwithstanding the protests from competent clinical staff in the Accident and Emergency

	Department at West Suffolk Hospital. The circumstances of this case raise concerns about the NHS approach to centralising exigent care in regional centres (such as the Royal Papworth Hospital for cardiac conditions) if the means to deliver the approach are inadequate. East of England Ambulance Service provided evidence to the Inquest, including a Report concerning its response. This plan is generalised, lacking detail and any means of measurement of progress and is inadequate in addressing the concerns raised at the Inquest.
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 March 11, 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: **Family of Dennis John William KING** I have also sent a copy to: **Royal Papworth Hospital NHS Foundation Trust** **West Suffolk Hospital NHS Foundation Trust** as other persons who I believe 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: 15/01/2024**  **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**