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 Rt Hon Victoria Atkins MP the Secretary of State for Health & Social Care, House of Commons, London SW1A 0AA [redacted], Chief Executive of North East Ambulance Service Foundation Trust, Bernicia House, Goldcrest Way, Newburn Riverside, Newcastle upon Tyne NE15 8NY [redacted]
1	**CORONER** I am Clare Bailey HM Senior Coroner for the Coroner's area of Teesside & Hartlepool
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** Donna Georgina Smith died at James Cook University Hospital, Middlesbrough on 17 July 2021. On 20 July 2021 I commenced an investigation into the death of Donna Georgina SMITH aged 51. The investigation concluded at the end of the inquest on 08 January 2024. The Medical Cause of her death is: 1a. Acute Left Ventricular Failure 1b. Diabetic Ketoacidosis and Coronary Artery Disease and Ischaemic Heart Disease I left a narrative conclusion as follows- Donna suffered chest pains at home on 17.07.21. The emergency services were contacted. She suffered a myocardial infarction which deteriorated into cardiac arrest. There were missed opportunities on behalf of the ambulance service to recognise that Donna was peri arrest and in turn upgrade the call category. The failure to upgrade the call category and the delay in the ambulance contributed to Donna's death.
4	**CIRCUMSTANCES OF THE DEATH** Donna Georgina smith's past medical history included two heart attacks, ischaemic heart disease, hypertension, and Type 2 Diabetes Mellitus. On 17.07.21 in the afternoon she described feeling lightheaded and went for a lie down. Approximately ten minutes later she told her husband she was having a heart attack. She was holding her chest in pain and collapsed to the floor. Her husband called for an ambulance at approx. 1500. The call was disconnected and a call handler from the North- East Ambulance Service (NEAS) returned the call at 1501. Donna was unable to talk properly because of her chest pain. A Category 2 disposition was allocated. This aims for an average ambulance response within 18 minutes, with a 95th percentile of 40 minutes.

At 1526 the family called NEAS describing worsening symptoms. Donna was unconscious and breathing slowly. The call was received by a call handler and remained as a category 2 disposition. The family made further chasing calls to NEAS. They contacted the police and fire brigade for assistance, both of whom contacted NEAS and were told an ambulance would be attending. Due to the number of calls received a clinician telephoned the family at 1537. NEAS accept that the questions and probing undertaken by the call handler were insufficient to ascertain Donna's position. The call handler asked the family if they could take her to hospital. The case was not re-categorised but was prioritised within the list of Category 2 dispatches.

A Dual Crew Ambulance arrived at 1606, one hour and six minutes following the first call. By that time the Fire Brigade had helped Donnas family place her on a stretcher and she was being transported to hospital in a family member's car. The Fire Brigade flagged down the ambulance which was not travelling under sirens or at speed. Donna was transferred to the ambulance. She stopped breathing and deteriorated into a state of cardiac arrest. CPR was provided and an ECG identified Ventricular Fibrillation. Following defibrillation, a return of spontaneous circulation was achieved. In line with NEAS protocol the crew awaited the arrival of a second ambulance. Enroute to the hospital Donna sustained a further cardiac arrest and resuscitation was provided. She arrived at hospital at 1714. She was sadly pronounced Deceased shortly after her arrival.

NEAS undertook an SI report. Oral evidence was provided by a Patient Safety Manager. It was clear that a comprehensive investigation had been undertaken and learning implemented. The Patient Safety Manager ("PSM") explained that if Donna was in peri-arrest when the Clinician called the family the call should have been categorised to a Category 1 call. This would have resulted in an average response time of 7 minutes, with the 95th percentile being 15 minutes. The escalation is because the peri-arrest is recognised as a life-threatening event.

I instructed an independent expert who determined that the delay in the ambulance arrival contributed to Donna's death. He also told me that Donna was peri-arrest at 1526, when the family called and described Donna's worsening condition to the call handler. She continued to be in peri-arrest when the clinician called at 1537.The failure to recognise this deterioration and act accordingly also contributed to Donna's death.

The PSM explained that NEAS now employ a dispatch clinician, who monitors the category 2 calls to see if they should be escalated in status. It is not guaranteed that they will spot each call that needs to be escalated. The other way a category 2 case is re-considered is if, as in this case, there are a high number of calls. If there are a high number of calls a clinician will consider the case and ring the family. This happened in Donna's case. My concern is that neither the call handler nor the computer recognised the significant change in Donna's health when the family called at 1526. She was in peri-arrest and the call should have been re-categorised as a Category 1 dispatch.

A further concern is that the category 2 call was not responded to in a timely fashion. It took one hour and six minutes for the ambulance to arrive to an emergency call.

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)

	1. The call handler did not detect a worsening condition and did not escalate the call from Category 2 to category 1. 2. The methods of detecting worsening conditions in existing category 2 calls are not sufficiently robust (dispatch clinician and numerous call condition). 3. The category 2 call target (18minute average response and 95th percentile a 40minute response) was breached and the ambulance arrived 1 hour and 6 minutes after the first call.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Rt Hon Victoria Atkins MP the Secretary of State for Health & Social Care, House of Commons, London SW1A 0AA The Chief Executive of North East Ambulance Service Foundation Trust, Bernicia House, Goldcrest Way, Newburn Riverside, Newcastle upon Tyne NE15 8NY (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 16, 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 , Donna's husband 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: 22 January 2024** **Clare Bailey** **HM Senior Coroner for Teesside & Hartlepool Coroner's Service**