	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] **- CEO Birmingham Integrated Care Board** • [redacted] **- NHS England, Midlands Regional Director** • **The Rt Hon Victoria Atkins MP - Secretary of State for Health and Social Care**
1	**CORONER** I am Emma Brown, Area Coroner for Birmingham and Solihull
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 4 December 2023 I commenced an investigation into the death of Jade Marie GRIFFITHS-JONES. The investigation concluded at the end of the inquest. The conclusion of the inquest was; "Death was due to natural causes in combination with a delay in ambulance attendance arising from increased demand for ambulances and significant hospital delays."
4	**CIRCUMSTANCES OF THE DEATH** **Mrs Griffiths-Jones died at the Queen Elizabeth Hospital on the 4th June 2023 as a result of severe and fatal hypoxic brain injury sustained during a cardiac arrest at around 15:00 hours on the 31st May 2023 caused by coronary artery disease. An ambulance had initially been called when Mrs Griffith-Jones started to suffer chest pain at 13:33 but an ambulance was not available to attend due to increased demand and delays handing over patients at hospitals. If an ambulance could have attended within national target times Mrs Griffith-Jones would have arrived at hospital before suffering a cardiac arrest and would have been likely to survive.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Hypoxic-ischaemic brain damage** **1b Cardiac arrest** **1c Coronary artery disease - percutaneous coronary intervention** **II Diabetes mellitus**
5	**<u>CORONER'S CONCERNS</u>** 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. During the inquest evidence was given on behalf of West Midlands Ambulance Service from [redacted], Learning Response Lead, that at the time of Jade's initial call reporting centralised chest pain at 13:33 on the 31st May 2023 the Trust was experiencing increased volume of calls and significant hospital delays and therefore could not resource the category 2 disposition within national target times (mean average of 18 minutes, 90th centile of 40 minutes). The call was still unresourced when she was reported to be in cardiac arrest during a further call at 15:01 (the 4th call). The Trust's Gold Dashboard that was captured closest to the clock start time for the first call (captured at 13:00:32) identified that there were delays in the mean and 90th percentile response times for Category 1, 2, 3 calls. There was 3 available ambulance resource within the sector at that point in time with 54 Category 2 and 43 Category 3 cases awaiting resource allocation, and 16 cases yet to be prioritised. There were regional hospital delays of up to 218 minutes. 2. For the 2 hours before Jade's call the Birmingham sector had been experiencing a 2 hour spike in demand. However, the real problem affecting resourcing was paramedic crews being stuck at hospitals awaiting handover. In 2023 to 2024 West Midlands Ambulance Service lost approximately 250,000 response hours due to delays at hospitals. 3. West Midlands Ambulance Service have taken a broad range of measures in recent years to tackle increasing response times including measures to reduce call demand through public education, to avert calls away from ambulance services and hospitals via clinical validation, to improve patient flow through intelligent conveyancing and to increase the number of resources in operation. Aside from seeking funding to recruit further paramedics and increase ambulance numbers alongside continued monitoring and learning there is nothing West Midlands Ambulance Service can identify that they can do to improve the situation further. 4. West Midlands Ambulance Service continue to fail to meet target response times and have been made the subject of a regulation 12 notice on this topic by the CQC. 5. The evidence of West Midlands Ambulance Service is that if hospital handover delays didn't exist they would be likely to be meeting their response targets as they did before hospital delays became chronic. In the circumstances it is my conclusion that the availability of ambulance crews is continuing to be compromised by delays at hospitals resulting in delays in response times which creates a risk to the life.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 12 June 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 : [redacted] (the deceased's cousin), [redacted] (the deceased's brother), West Midlands Ambulance Service. I have also sent it to the CQC, 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	**17 April 2024** Signature:  **Emma Brown** **Area Coroner for Birmingham and Solihull**