HM Senior Coroner
for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt Hon Victoria Atkins MP** **The Secretary of State for Health & Social Care** **39 Victoria Street** **London** **SW1H 0EU**
1	**CORONER** I am David Ridley, Senior Coroner for Wiltshire and Swindon
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 the 15 December 2021 I opened an Inquest into the death of Richard Carpenter who was born on the 18 February 1950 and who died at his home address during the early hours on the 1 December 2021 aged 71. His Inquest was finally concluded today (23 April 2024). At the final hearing Inquest, I found that the medical cause of death was: 1a. Haemothorax 1b. Bleeding from Site of Cardiac Surgery 1c. Mitral Valve Replacement (November 2021) for Severe Mitral Regurgitation In relation to the when, where and how Richard came by his death, I recorded as follows: "*Richard underwent elective complex heart surgery on 19 November 2021 that included a Mitral Valve repair and also a single vessel Coronary Artery Bypass Graft. He was discharged home on 28 November 2021. Late evening on 30 November 2021 he developed pains down his left side. He became unresponsive during the early hours on 1 December 2021 and was confirmed dead at home at 0500 the same day. He died as a consequence of a complication following surgery when he developed a bleed more likely than not from the surgical site.*" My conclusion as to Richard's death was that it was an ACCIDENT.
4	**CIRCUMSTANCES OF THE DEATH** As you will see from what I recorded on the Record of Inquest, Richard underwent elective major cardiac surgery in Bristol on 19 November 2021 and was discharged home on the 28 November 2021. Late evening on the 30 November 2021 he developed increasing pain down his left side and shortly after 22:30 that evening his wife made the first of a number of calls to the ambulance service. Although Richard was categorised as a CAT 2 response records show that an ambulance did not arrive at Richard's home address until 04:11 on the 1 December, some 5

	hours 34 minutes and 36 seconds from the time of the first call by which time Richard was unresponsive and despite advanced life support his death was confirmed at 05:00 the same morning. You will of course be aware that the target response time for a Category 2, I understand, is 18 minutes. At the final hearing I admitted evidence under Rule 23 of Coroners' (Inquests) Rules 2013 from [redacted] who undertook the cardiac surgery on Richard in November 2021 and his evidence was that even if Richard had been got to hospital within say an hour of the original call the outcome would only have possibly been more favourable and the use of the word possibly does not meet the level of certainty that is required to establish causation which works on a balance of probabilities.
5	**CORONER'S CONCERNS** During the course of the Inquest I heard evidence from the Southwest Ambulance Trust from [redacted] who is the Deputy Head of Clinical Operations in Safety and he explained in detail the pressures that all ambulance trusts were under at that particular time and he also explained new ways of working with a view to reducing the number of outstanding unallocated calls including the use of the National Model for Clinical Navigation and the use of ambulance personnel at hospital in an attempt to free up ambulances although I did hear that it is not uncommon for around 30% of available ambulances to still be held up at hospitals in our area waiting for a handover. The reason I am submitting this Regulation 28 Report is that I heard evidence when I put the question to [redacted] as to whether or not the Trust is hitting its targets in relation to ambulance response, and I was told that the Trust was not meeting those targets consistently in a way comparing to pre-pandemic times. When I drilled down further as to where problems lay, again the issue of patients in hospitals taking up beds arose in circumstances whereby the patient was physically fit for discharge but they were not able to be discharged due to the lack of appropriate care packages in the community. This issue has arisen in other Regulation 28 Reports that I have written to you recently and I am concerned as regards the lack of availability of sufficient free beds in hospital due to bed blocking is still causing significant disruption to ambulance services trying to transfer patients to hospital. Although on this occasion I did not find a causal link between the delay and Richard's death, I am concerned that delays in ambulances attending patients in the community are likely to increase the risk of death in Cat 2 instances especially that would otherwise be preventable had the patient been got to hospital in a timely fashion. What is also of a concern is that what used to be considered seasonal pressures on ambulance services during the winter months is now becoming an all year round norm. As previously stated in other recent Regulation 28 Reports addressed to you any solution to the overall issues affecting the NHS will relate to matters of Government policy and resourcing. I am sure that the family here would appreciate an indication as to the national strategy here to address this issue over and above providing additional funding which tends to be the general response that, in my experience, is the usual reply.
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 20 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, Family of the Deceased [redacted], South Western Ambulance Service, NHS Foundation Trust 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 25 April 2024 Signature [signature] David Ridley, Senior Coroner for Wiltshire & Swindon