	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NHS England at [redacted] FAO: NHS England Standardising Acuity Measures in Emergency Departments/Urgent Treatment Centres 2. [redacted], Chief Executive, National Institute for Health and Care Excellence at [redacted] 3. [redacted], President of The Royal College of Emergency Medicine at [redacted] FAO Quality Tea 4.
1	**CORONER** I am Xavier Mooyaart, an assistant coroner for the coroner area of Inner South London.
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 19 October 2021 an investigation commenced into the death of Kasey Beech, a 19-year-old woman who died following a cardiac arrest caused in turn by a likely infective exacerbation of her longstanding asthma. Her inquest was concluded on 8 November 2023. The conclusion of the inquest was that she died by natural causes. Following the inquest further submissions and evidence were sought in relation to the risk of future deaths.
4	**CIRCUMSTANCES OF THE DEATH** On 5 October 2021 Ms Beech self-presented to the urgent treatment centre at Medway Maritime Hospital (MMH), in light of difficulty breathing. She had also been experiencing chest pain. At MMH the traditional Accident & Emergency service has been replaced by an Urgent Treatment Centre (UTC) for walk-in patients. The UTC operates the nationally stipulated STREAMing model ('Simple Triage Rapid Emergency Assessment Method'), a system whereby patients are assessed on arrival and sent to the appropriate area for further review and care. Ms Beech was assessed and directed to the Medway on Call Care (MedOCC), where she was informed of a three hour wait. She decided to go to a friend's

	home nearby where she could access a nebuliser more promptly. Shortly after arrival there her breathing worsened suddenly, she was unable to inhale deeply from the nebuliser and she arrested. She was subsequently taken by ambulance to MMH, and then transferred to St Thomas' Hospital London. Despite treatment she did not recover and she passed away at St Thomas' on 13 October 2021.
5	**CORONER'S CONCERNS** 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. – The focus of the current STREAMing guidance regarding the assessment of new non-injury ambulatory patients able to speak in complete sentences without becoming out of breath is on chest pain. The assessment relates to *current* chest pain and diagnostic investigations are in turn centred on whether there is a cardiac cause. Such patients who do not present with *current* chest pain are sent to the MedOCC. However: (i) pain can fluctuate over time and may not always be concurrent with the initial assessment; (ii) pain may be masked by analgesia taken prior to assessment; and (iii) the focus on a cardiac cause itself risks diverting a clinician from the wider question of identifying the cause of the pain. The consideration of differentials that may be immediately life-threatening, or place the patient at risk of a sudden deterioration (e.g. infective exacerbation of asthma) may be delayed, or not given adequate attention as a consequence. While it is understood that a cardiac issue is high risk and requires prompt diagnosis, and that the exclusion of a cardiac cause causing current chest pain is also diagnostically helpful, I am concerned that the prioritisation of current cardiac-sounding chest-pain and the streaming to a MedOCC/equivalent service may be to the detriment of other patients who are nonetheless at risk of sudden deterioration and therefore creates a risk of future deaths (in both cardiac and non-cardiac patients). It is understood that the current national guidelines are under review.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Thursday, 24th October. 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, to the family and to the other Interested Persons (Medway NHS Foundation Trust, and Medway Community Healthcare) 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 other 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.
9	**[DATE]** **[SIGNED BY CORONER]** Thursday, 29th August 2024 Mr Xavier Mooyaart