IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Philip Gordon Ross
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive South East Coast Ambulance Service NHS Foundation Trust Nexus House 4 Gatwick Road Crawley RH10 9BG
2	**CORONER** Ms Susan Ridge, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into Mr Ross's death was opened on 4 January 2024. The inquest was resumed and concluded on 23 August 2024. The medical cause of Mr Ross's death was: 1a. Multiple Organ Failure Ib. Bronchopneumonia and Rhabdomyolysis Ic. Fall 2. Myocardial Fibrosis

	With respect to where, when and how Mr Ross came by his death it was recorded at Box 3 of the Record of Inquest as follows: > Philip Gordon Ross had a fall at his home injuring his shoulder sometime before 2325 hours on the evening of 3 December 2023. He was unable to move until extracted by paramedics and he was taken by ambulance to the Royal Surrey County Hospital Guildford and admitted to the Emergency Department at around 0416 hours. Within a day or so of admission he was found to have acute kidney injury secondary to rhabdomyolysis, symptoms of myocardial injury and pneumonia. He did not respond to treatment and his condition continued to deteriorate. Mr Ross died on 19 December 2023 at the Royal Surrey County Hospital of multiple organ failure caused by rhabdomyolysis and bronchopneumonia precipitated by his fall on a background of myocardial fibrosis. The inquest concluded with a short form conclusion of 'Accident':
5	**CIRCUMSTANCES OF THE DEATH** On 3 December 2023, Mr Ross suffered a fall at his home and was unable to move. His wife called for an ambulance at 23:25 hours. At that point his case was categorised by South East Coast Ambulance Service (SECAMB) as a Category 3 case. Category 3 calls have a response time of 120 minutes. Mrs Ross then made a number of increasingly anxious calls to the ambulance service about the need to help her husband, these included a call at 00:48 hours. It was accepted in evidence that Mr Ross should have been re-triaged at this point as his condition had deteriorated. The court heard he was not triaged again until 01:42 hours, when a nurse clinical supervisor upgraded the call to Category 2 with a response time of 18 minutes. The ambulance did not arrive until around 02:30 hours. SECAMB have adopted the NHS England protocol for validating Category 3 and Category 4 ambulance calls. They therefore aim to validate such cases within 90 minutes of the call. That was not achieved in Mr Ross's case. The evidence showed that no form of clinical validation of the calls took place until approximately 2 hours and 20 minutes after the initial call.

	The court heard that the delay in an ambulance attending Mr Ross was because there had been a high demand for ambulance/paramedic assistance over that period. And that no clinical validation of the calls took place until well over 2 hours from the initial call because of a lack of available clinical staff or clinical hours to deal with the level of surge in calls that night.
6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: Under the Ambulance Response Programme, Category 3 and 4 cases have response times of 120 and 180 minutes respectively. SECAMB aim to validate these calls within 90 minutes to ensure that patients receive the most appropriate care at the right time. However, SECAMB have not produced evidence that their timeline for clinical validation is being met and it was not met in this case. Categories 3 and 4 are deemed less serious cases and therefore have extended response times for ambulance attendance, which can become further extended at times of high demand. Because of these potentially long response times, timely clinical validation is important to ensure correct categorisation and/or identify a deteriorating situation. The coroner is concerned that late re-triage or clinical validation of Category 3 and 4 calls is placing patients at risk of early death.
7	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Ross's family
10	**Signed:** **Susan Ridge** **H.M Assistant Coroner for Surrey** **Dated this 16th day of September 2024**