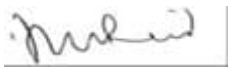
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Secretary of State of Health and Social Care, 39 Victoria Street, London SW1H 0EU.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** I make this report 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 11 March 2024 I commenced an investigation and opened an inquest into the death of Henry Michael Patrick WILLEMS. The investigation concluded at the end of the inquest on 21 October 2024 The conclusion of the inquest was that Mr. Willems *"died from natural causes, to which the lack of a timely ambulance response contributed."*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mr. Willems come by his death?", I recorded as follows: *"In the early hours of 12.10.23 Mr. Willems, who had been unwell with gastritis over the preceding 48 hours, collapsed at his home in Malvern. His family called the emergency services, and paramedics attended him at home, but he was confirmed deceased a short time later. Paramedics had been unable to attend Mr. Willems' address within the mean target response time for a Category 2 case because ambulances were experiencing significant delays in handing their patients over to staff at hospital emergency departments across the region. Had that mean target response time been met, it is likely that Mr. Willems would have survived."* A post mortem examination confirmed the medical cause of death for Mr. Willems was: 1a ischaemic heart disease.
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) In the course of the inquest, I heard evidence from the Patient Safety Learning Lead for West Midlands Ambulance Service University NHS Foundation Trust (WMAS), who told me:

	(a) Mr. Willems' case was correctly assigned a Category 2 disposition, for which the mean response time is 18 minutes, and the 90th percentile response time is 40 minutes; (b) Those response times were not met, as Mr. Willems was not reached by paramedics until some 2 hours 18 minutes after the "clock start" time for his case; (c) The Trust was unable to meet the applicable mean and 90th percentile response times, because at the time of these events, it was operating at Emergency and Urgent Surge Level 4 (the highest level which can be applied). The Trust had over 200 outstanding incidents, of which 31 were other Category 2 cases, and 50% of their vehicles were being delayed at hospitals within the region for anything between 189 minutes and 441 minutes. 2) I heard expert evidence that Mr. Willems would probably have survived this episode, and would not have died when he did, had paramedics been able to attend his home address within the applicable 18 minute mean response time.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Secretary of State for Health and Social Care, 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 **16th December 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: (a) [redacted], Mr. Willems' daughter; (b) West Midlands Ambulance Service University NHS Foundation Trust; (c) Worcestershire Acute Hospitals NHS 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	**21 October 2024**  **David REID** **HM Senior Coroner for Worcestershire**