Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England**
1	**CORONER** I am Rachel Redman, Assistant Coroner for the coroner area of East Sussex.
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 09 May 2022 I commenced an investigation into the death of Keith David FOORD aged 76. The investigation concluded at the end of the inquest on 08 November 2024. The conclusion of the inquest was that: Dr K D Foord sustained a Type A Aortic dissection on 2.5.22. His symptoms caused him to request an ambulance to go to the A and E Department at Conquest Hospital, Hastings arriving at 9.30am that day. An accurate diagnosis was made at 12 midday and arrangements were made with Royal Sussex County Hospital, Brighton to transfer his care to their cardiac surgery unit. A Category 2 ambulance was called for which took 1hr 19 minutes to arrive, 1 hr later than the 18 minute response time required by a Category 2 case. Dr Foord was taken to theatre and underwent a lengthy operation, but the right coronary artery had completely detached from the aorta by the time surgery began which disaffected significantly his chances of survival. Dr Foord died at 7.30am on 3.5.22, the cause of death being:- 1a) Acute type A Aortic Dissection (Emergency Aortic Repair 2/5/22).
4	**CIRCUMSTANCES OF THE DEATH** Dr Foord died as a result of an Acute type A Aortic Dissection in spite of undergoing emergency repair on 2nd May 2022. He had presented to A and E at The Conquest Hospital where the correct diagnosis was made in a timely manner. He required an ambulance to take him to Royal Sussex County Hospital, Brighton where the regional cardiac surgery is undertaken. His case was categorised as 2 for response time for the ambulance service when all of the clinical, paramedic and expert witnesses whose evidence I heard at the inquest advised that it should be correctly categorised as 1 given the critical requirement for emergency surgery.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: During the course of the investigation my inquiries revealed matters giving rise to concern, namely that for aortic dissection requiring emergency surgery and inter facility transfer, the category of this type of case for transfer should be raised to category 1. 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.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 January 27, 2025. 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:- Dr Foord's family East Sussex Healthcare NHS Trust South East Coast Ambulance Service I have also sent it to Royal Sussex County Hospital Cardiac Surgery Directorate who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 02/12/2024** Rachel Redman **Rachel REDMAN** **Assistant Coroner for** **East Sussex**