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 Department of Health and Social Care** **2 NHS England & NHS Improvement** **3 The Chief Coroner**
1	**CORONER** I am Anita BHARDWAJ, Area Coroner for the coroner area of Liverpool and Wirral
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 07 October 2024 I commenced an investigation into the death of Nicola Emma OWENS aged 40. The investigation concluded at the end of the inquest on 30 January 2025. The conclusion of the inquest was that: **Cause of Death** 1a. Hyperosmolar Hyperglycaemic State b. Undiagnosed Type 2 Diabetes Mellitus II. Morbid Obesity **Narrative Conclusion** The unavailability of an ambulance to convey Nicola to hospital for necessary emergency treatment for undiagnosed type 2 diabetes mellitus resulting in a terminal cardiac event. This being a preventable death.
4	**CIRCUMSTANCES OF DEATH** On 07 October 2024 I commenced an investigation into the death of Nicola Emma OWENS aged 40. The investigation concluded at the end of the inquest on 30 January 2025. The conclusion of the inquest was that: Nicola Emma Owens was a 40 year old lady who had numerous co-morbidities, including obesity and a recent history of vomiting and diarrhoea. At approximately 14:00 hours on 4 October 2024 Nicola suffered a collapse whilst at work. She felt generally unwell but was talking. Five 999 calls were made to North-West Ambulance Service requesting their attendance. Paramedics arrived at 21:50 hours, by which time Nicola had deteriorated. She was placed in the ambulance where she proceeded to suffer a cardiac arrest at 22:40 hours. Nicola was then conveyed to the Royal Liverpool University Hospital at 22:49 hours having ongoing cardiopulmonary resuscitation (CPR), despite active treatment Nicola was pronounced deceased at 00:25 hours on 5 October 2024. The post mortem examination found Nicola died as a result of hyperosmolar hyperglycaemic state (HHS) caused by undiagnosed type 2 diabetes mellitus. HHS is a life-threatening complication of diabetes and occurs when the blood glucose (sugar)

	levels are too high for a long period leading to severe complications, including hyperkalaemia. HHS is a medical emergency and without treatment, it carries a high risk of mortality. Nicola did not appear to be critically unwell following her collapse but became progressively more unwell whilst waiting 7 hours and 28 minutes for an ambulance to arrive. From the evidence heard it is more likely than not, had Nicola been conveyed to hospital earlier the potassium salt levels could have been reversed and she would have survived. High potassium salt in the blood leads to cardiac arrhythmias and is treatable and reversible on most occasions. The cause for the delay in an ambulance attending to Nicola was due to the unavailability of ambulances at that time. This delay being significantly contributed to by the handover delays across numerous hospitals across the North-West. A significant factor contributing to the handover delays in the Royal Liverpool University hospital was a backlog of patients who were fit for discharge but awaiting social care packages.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. 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: (brief summary of matters of concern) The delay in an ambulance attending patients due to the unavailability of ambulances. This delay being significantly contributed to by the handover delays in hospitals. A significant factor contributing to the handover delays in hospitals being the backlog of patients who are fit for discharge but awaiting social care packages. Overall, this entails a lack of staff and room for those patients who are brought in via ambulance thus requiring ambulance crews to remain on hospital premises reducing their ability to attend seriously ill patients.
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 March 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 **1. [redacted] (mother)** **2. [redacted] (brother)** **3. North-West Ambulance Service** I have also sent it to **1. The Royal Liverpool University Hospital** 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. They may send a copy of this report to any person who they believe 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: 31/01/2025**  **Anita BHARDWAJ** **Area Coroner for** **Liverpool and Wirral**