Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 DEPARTMENT OF HEALTH.** **2 NHS ENGLAND.** **3 NHS NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD.**
1	**CORONER** I am Paul Appleton, Assistant Coroner for the Coroner Area of Teesside and Hartlepool
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 18 September 2024 I commenced an investigation into the death of Diana FAIRWEATHER-PURKIS, aged 79. That investigation concluded at the end of the inquest on 14 February 2025. The conclusion of the inquest was: *Diana died due to multi-organ failure secondary to urosepsis. Diana's death was contributed to by: naturally occurring comorbidities, delays in ambulance attendance, and delays in the prescription and administration of antibiotics.*
4	**CIRCUMSTANCES OF THE DEATH** Following a call to the 111 Service at 22:14 on 30 September 2022, Diana was allocated a Category 3 Ambulance disposition at 22:21. The target response time for that Ambulance to attend was 2 hours. At 07:58 on 01 October 2022, that Ambulance disposition was upgraded to Category 2 with a target response time of 18 minutes. An Ambulance then attended to Diana at 08:10 on 01 October. The total time from the initial call to the 111 service to Ambulance attendance was therefore 9 hours and 56 minutes. Diana was transferred by Ambulance to the University Hospital of North Tees, where she arrived at approximately 09:05AM and was admitted. Sadly, Diana deteriorated and died in hospital on 3 October 2022 due to multi-organ failure secondary to urosepsis.
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: 1. There is insufficient Ambulance Service availability/resource to enable Ambulances to attend to patients in a timely manner and in accordance with relevant target attendance times. 2. There are excessive delays in Ambulance crews being released following attendance at hospital, due to delays in patients being handed over to hospital staff.

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 12 April 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. Family. 2. North East Ambulance Service NHS Foundation Trust. 3. North Tees and Hartlepool NHS Foundation 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. She may send a copy of this report to any person who she 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: 17/02/2025** **Paul APPLETON** **Assistant Coroner for** **Teesside and Hartlepool Coroner's Service**