David Place
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Director of Operations of The Nerams Group**
1	**CORONER** I am David Place, His Majesty's Senior Coroner for the City of Sunderland
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 15th January 2025 I commenced an Investigation into the death of Mr Jack Matthew Shields, who was born on 17th May 1994 and who died at [redacted], Sunderland on 28th April 2024 aged 29 years. The Investigation concluded at the end of the Inquest on 25th February 2025. The narrative conclusion of the Inquest was 'Deterioration of a heart condition whilst an ambulance allocation was significantly delayed following a missed opportunity to assign an earlier available ambulance'. The medical cause of death was: - Ia Heart Failure II Aortic Dissection
4	**CIRCUMSTANCES OF THE DEATH** Jack Matthew Shields was a 29 year old male with a past medical history outlining extensive heart conditions. Jack had three previous open-heart surgeries including aortic dissection. On the evening of 27th April 2024 Jack experienced shortness of breath, and his mother called 999 at 23:14hrs that night. This was categorised as Cat 2. Following a clinician callback at 00:27am on 28th April 2024 an ambulance was allocated at 00:31am and arrived on scene at 00:36am. This was over an hour later than the national average response time for Cat 2 patients.

	It later transpired after an investigation by NEAS following Jack's death, that another ambulance had been available at 23:24am and, if allocated, would have arrived on scene at 23:36hrs on 27th April 2024. At 00:52 on 28th April 2024 an amber backup request was made, and a rapid response paramedic arrived at 01:07am. A third crew arrived at 01:36am, but Jack had already deteriorated into a cardiac arrest. The backup request was incorrectly categorised by the crew as Jack's condition was clearly deteriorating, and he was acutely unwell due to reducing blood pressure over a short time, tachycardia and an ECG revealed an ST-Elevated Myocardial Infarction. He required a higher priority backup. Jack died at his home address of [redacted], Sunderland despite extensive resuscitation attempts with his death declared at 02:27am on 28th April 2024.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is: – At 00:36am on 28th April 2024 the first ambulance arrived at the scene, which was 1 hour and 22 minutes following the initial call being received. This was a technician led dual crew ambulance provided by NERAMS - a third-party provider. The crew informed the Emergency Operations Centre at 00:52am on 28th April 2024 that an amber request for paramedic assistance was required. A rapid response paramedic arrived at the scene at 01:07am on 28th April 2024. Unfortunately, Jack deteriorated into a cardiac arrest and despite resuscitative efforts, he was declared deceased at 02:27am on 28th April 2024. The evidence was clear that Jack's condition at the time of the first ambulance arrival at 00:36am was such that a higher priority backup should have been requested. Jack was symptomatic of cardiogenic shock with descending blood pressures, shortness of breath, nausea and vomiting, and required the highest priority backup of Cat 1 (Peri Arrest). I am concerned that the crew should have recognised the deteriorating condition when considering relevant observations such as ECG interpretation, an early recognition of such a deterioration and a correct categorisation of a backup request may have led to rapid stabilisation and transportation to definitive care. I shall be glad to be told of any learning arising from this death and timescales and results of your review.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 30th 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: - • Family • North East Ambulance Services and their Solicitors • Care Quality Commission 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	Dated this 4th day of March 2025 Signature:  HM Senior Coroner for the City of Sunderland