HERTFORDSHIRE CORONER

The Old Courthouse, St Albans Road East, Hatfield, Hertfordshire, AL10 0ES

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health & Social Care**
1	**CORONER** I am Jacques Howell, area coroner, for the coroner area of Hertfordshire
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 1 June 2023 an investigation was commenced into the death of Paul Anthony Burke, aged 41. The investigation concluded at the end of the inquest on 25 April 2025. The conclusion of the inquest was that Mr Burke died as a consequence of Type 2 Respiratory failure, the underlying cause of which was not promptly identified nor treated, thereby contributing to his death. The medical cause of death was found to be: 1a. Type 2 Respiratory Failure 1b. Obesity Hypoventilation Syndrome and Congestive Cardiac Failure 2. Obesity – Grade 3
4	**CIRCUMSTANCES OF THE DEATH** Mr Burke was a 41-year-old gentleman with a past medical history that included Obesity Hypoventilation Syndrome. On 19 December 2022 he called for an ambulance due to experiencing worsening shortness of breath. The first call to the ambulance service was at 14:07hrs. This generated a category 2 response, requiring an ambulance resource within an average of 18 minutes, with 90% of calls being responded to within 40 minutes. There were further calls to the ambulance service at 14:59hrs, 16:31hrs and 19:09hrs. Throughout this time, the call remained as a category 2 response. No ambulance resource was sent. The final call to the ambulance service was at 20:16hrs, a little over 6 hours from the original call to advise the ambulance service that Mr Burke was being taken to hospital by car by members of his family who had come to assist. Mr Burke arrived at Watford General Hospital at around 20:51hrs. During initial assessment a venous blood gas (VBG) identified that he was experiencing Type 2 Respiratory Failure,

	and he was therefore transferred to the resuscitation area of the emergency department. Over the following hours he was reviewed by a number of clinicians, all of whom were not aware of the VBG result, and made a diagnosis of fluid overload due to likely heart failure. However, there was no detailed consideration of the underlying cause for Mr Burke's worsening respiratory function even though his past medical history of obesity hypoventilation syndrome was known. At around 22:30hrs on 20 December 2022, Mr Burke's condition deteriorated. Arterial blood gas (ABG) testing was undertaken which showed that he was significantly unwell and in Type 2 Respiratory Failure. Consequently, Mr Burke was transferred to the Acute Respiratory Care Unit and was placed on non-invasive ventilation. Sadly, this was not successful and Mr Burke suffered a respiratory collapse and passed away at 07:44hrs on 22 December 2022. On the facts of this particular case, whilst the inability of the ambulance service to send a resource to Mr Burke leading to his delayed presentation to hospital was recognised; the delay was unlikely to have more than minimally contributed to his death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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. Delay in ambulance response and the consequent delay in the provision of pre-hospital emergency care.** As set out above, Mr Burke first made a call to the ambulance service at 14:07hrs on 19 December 2022. The call was triaged as requiring a category 2 response, requiring a response within an average of 18 minutes, with 90% of calls being responded to within 40 minutes. I received evidence that category 2 calls are for those whose condition is potentially serious and require rapid assessment, urgent on scene intervention or urgent transport to hospital. By way of example, patients who fall within this category can include those who are unconscious, experiencing chest pain or suffering with stroke symptoms. Despite the urgency with which an ambulance was required for Mr Burke no ambulance resource was available. It was only due to the intervention of his family who came to his aid that he was able to get to hospital – others may not be so fortunate. I heard evidence that on 19 December 2022, the local ambulance service was under extreme pressure. At 14:40hrs on 19 December 2022, the ambulance service had a total of 243 outstanding category 2 calls waiting for an ambulance response. 37 of these were within the Hertfordshire area. This was compounded by the fact that 11 ambulances were delayed at Watford General Hospital, one of which had been waiting to handover their patient for over 5 hours. At 18:01hrs on 19 December 2022, this had grown to 315 outstanding category 2 calls waiting for an ambulance response. 47 of these were within the Hertfordshire area. This was compounded by the fact that 9 ambulances were delayed at Watford General Hospital, waiting to hand over patients. Whilst it is clear that the ambulance service were under extreme pressure on 19 December 2022, on the evidence I heard, this is not an isolated incident. In December of 2022 the average response time for a category 2 ambulance was 61 minutes. In December 2023 the

	average response time for a category 2 ambulance was 125 minutes. In December 2024 the average response time for a category 2 ambulance was 50 minutes. These times are against a target average response time of 18 minutes. The East of England Ambulance Service (EEAS) has and continues to take action in conjunction with relevant stakeholders to try and minimise these delays. However, there is only so much they and other parties can do. On the evidence that I heard the reasons for ambulance delays appear to be multi-factorial and includes issues throughout the wider health system and are issues not unique to Hertfordshire. In light of the above, I have a concern that is a risk of future deaths occurring due to continuing delays in the provision of pre-hospital emergency care which appear to be multi-factorial in nature.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 27 June 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. The family of Mr Burke 2. The East of England Ambulance Service 3. West Hertfordshire Teaching Hospitals NHS Trust 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. 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.
9	 Dated: 2 May 2025 Jacques Howell Area Coroner for Hertfordshire