M. E. Voisin
His Majesty's Senior Coroner
Area of Avon

7 July 2025 REF: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **Association of Ambulance Chief Executives (AACE)**
1	**CORONER** I am Debbie Rookes, Assistant Coroner for the Coroner Area of Avon
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 3 December 2024 an investigation was commenced into the death of David Stewart Gifford. The investigation concluded at the end of the inquest on 30 June 2025. The conclusion of the inquest was: **Natural causes** The cause of death was recorded as: **1a Ruptured thoraco-abdominal aortic aneurysm** **1b Fractured stent and endoleak** **1c Aortic dissection and multiple aortic aneurysms - stented**

4	**CIRCUMSTANCES OF THE DEATH** David Gifford had an extensive medical history with significant co-morbidities. He had a long cardiac history which included aortic dissection, multiple aortic aneurysms and heart failure. He first underwent surgery for aortic dissection in 2006. He subsequently underwent further surgery on multiple occasions for further stenting and grafting to repair additional ruptures to his aorta. He developed an endoleak which was monitored and remained stable for many years, until it required surgery in 2023. Mr Gifford died on 26 November 2024 at Southmead Hospital. His death was caused by an acute ruptured abdominal aortic aneurysm, following the development of a fractured stent and endoleak at some point in the weeks preceding his death. It was not clear for exactly how long this endoleak had been present, or when the fracture occurred. In the weeks before his death, Mr Gifford had had multiple visits to his GP surgery. He was a complex patient with a number of medical condition and he had been experiencing a range of symptoms. The clinicians he saw referred him for further investigations into his symptoms. In the afternoon of 25 November 2024, Mr Gifford made a 999 call to the ambulance due to right-sided neck pain which radiated down his back and to his flank. He had been experiencing this pain since August 2024. Paramedics attended in the evening, and after an assessment, they did not think he needed to be conveyed to hospital. Worsening advice was given which resulted in Mr Gifford calling 999 again late that evening and an ambulance arrived in the early hours of 26 November 2024. He was conveyed to hospital and then transferred to Southmead Hospital, where he lost cardiac output whilst still on the trolley.

	There were concerns raised about recognition of an Abdominal Aortic Aneurysm (AAA), and its rupture. Whilst training and knowledge focuses on identification of any 'red flag symptoms', it is well known that a number of AAA's do not present in this way, resulting in a group of patients who are challenging to diagnose, and who may be missed.
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 will 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) Training and knowledge focuses on the classic signs and symptoms associated with an AAA. However, there are a group of patients who will not present in this way, and who may be challenging to diagnose. Whilst there may be many medical conditions that could be similar, there does not seem to be much focus given to the identification of vascular emergencies within training and knowledge updates. Therefore when paramedics attend emergencies, in the absence of classic symptoms, they may be wrongly reassured. Where a person has an extensive aortic history, the importance of aortic pathology should be considered. (2) There has not been training or medical education for ambulance on vascular emergencies for a long time. The evidence was that JRCALC guidelines did recently highlight the number of patients that may not present with the traditional 'red flags' but did not provide further guidance. This is a national issue where ambulance staff should be knowledgeable about the more subtle signs of vascular emergencies that may be missed.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the Association of Ambulance Chief Executives, 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 2 September 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 [redacted], son, and [redacted], daughter-in-law of the deceased, and to the Chief Coroner. I have also sent a copy to South Western Ambulance Service 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. 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	7 July 2025 Debbie Rookes Assistant Coroner