REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, East Midlands Ambulance Service NHS Trust** **2. The Chief Executive, Nottingham Emergency Medical Service** **3. NHS England** **4. Nottingham and Nottinghamshire Integrated Care Board**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 19th May 2025, I commenced an investigation into the death of Adam Ali Hussain The investigation concluded at the end of the inquest on the 12th December 2025 The conclusion of the inquest was a narrative conclusion as follows: Adam died from complicated appendicitis with perforation and peritonitis on 16.5.25, this illness developing over a three day period, with worsening abdominal pain, vomiting and clear evidence of sepsis on the day prior to his final admission, which followed a cardiac arrest at home. There were many opportunities missed by the East Midlands Ambulance Service, (EMAS) and by the Nottingham Emergency Medical Service (NEMS) to recognise the severity of his illness, and to ensure a face to face assessment, most particularly and obviously on 14.5.25. the day prior to his collapse at home on 15.5.25. No organisation with whom there was contact, recognised that there were repeated calls for assistance over the days prior to his death. The issues of care identified at both EMAS and NEMS on 14.5.25 have on balance made a more than minimal, negligible or trivial contribution to Adam's death.
4	**CIRCUMSTANCES OF THE DEATH** Adam died on 16.5.25 at Queens Medical Centre, Nottingham from complicated appendicitis with perforation leading to peritonitis, severe intra abdominal sepsis, and multiple organ failure. He and his family had contacted emergency services at 07.20 hours, 08.37 hours, and 16.22 hours on the 12th May 25, and then again at 12.45 hours, and at 20.37 hours on the 14th May 25 (that is the 111 service, and again via 999), repeatedly asking for help for worsening abdominal pain, persistent vomiting, and then with dizziness, breathlessness, weakness and an inability to walk without falling by lunchtime on the 14th.

	Appendicitis was undoubtedly present on the morning of 12.5.25 when he was seen at the Urgent Treatment Centre, but it was likely in its early stages and uncomplicated at this time. It was not unreasonable to allow him home at this time, with worsening advice. Adam followed this advice and rang again on that day as he was worse. By late afternoon on the 12th he had systemic symptoms of shivering and breathlessness, certainly signs of a systemic infection, perhaps early signs of sepsis. He required a face to face assessment at this time which did not occur. He appeared a little better on the 13th though blood tests were abnormal with signs of a bacterial infection. By lunchtime on the 14th, when Adam rung again, he had established intra abdominal sepsis which was missed, both at this time and again late evening on the 14th. Had he had a face to face assessment organised as should have occurred on the 14th, he would on balance have survived. There are serious issues of care identified on the 14th in respect of East Midlands Ambulance Service (EMAS) and the Nottingham Emergency Medical Service (NEMS), with a lack of recognition of the severity of illness, lack of recognition of signs of sepsis, and calls passed from EMAS to NEMS with limited clinical information only. There also was a lack of consideration by EMAS of key clinical information passed from 111 to EMAS at lunchtime on the 14th, and additionally this 111 information was then not passed on to NEMS to aid further assessment. There was confusion as to the management of Category 3 ambulance response calls, with a lack of clarity as to the inclusion/exclusion criteria agreed between EMAS and NEMS for call transfer. The number of emergency calls from the 12th to the 14th were evidence of Adams persistent and worsening symptoms, and therefore the need for face to face assessment and necessary treatment. This was not recognised by EMAS, nor by NEMS.. Had Adam been seen face to face on the 14th, it is very likely that the intra abdominal sepsis would have been recognised and treatment provided, likely leading to him surviving what is a treatable condition in a previously fit and well young man.
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. The urgent care pathway across Nottinghamshire, whilst working well for most patients, poorly serves patients with systemic illness that is serious, but not immediately life threatening, (such as is seen in sepsis), and where clinical assessment disposition reached is for a Category 3 ambulance response 2. There remains detailed information in the EMAS Computer Aided Dispatch (CAD) transferred from the 111 service that is not reliably read or considered by EMAS staff, when cancelling a requested ambulance response and referring a case on to the Clinical Assessment Service provided by NEMS. 3. Families, waiting for an ambulance response, following a clinical assessment by a 111 clinical adviser are not told by EMAS that an ambulance will not be sent

	4. Category 3 calls are viewed by non- clinicians at the EMAS Emergency Operations Centre, who do not have sufficient skills to safely transfer calls to NEMS, as the inclusion/exclusion criteria are open to interpretation 5. There is no agreement between EMAS and NEMS as to the criteria for transfer of a category 3 call, including whether or not a previous clinical validation would preclude transfer to NEMS I am not reassured that necessary actions to address these serious issues identified are in place.
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 the **2nd March 2026.** 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. Mr Hussain's family 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. 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.