## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Chief Executive, East Midlands Ambulance Service NHS Trust**<br>**2. The Chief Executive, Nottingham Emergency Medical Service**<br>**3. NHS England**<br>**4. Nottingham and Nottinghamshire Integrated Care Board** |
| 1 | **CORONER**<br><br>I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 20th January 2025 , I commenced an investigation into the death of Jake Kieran Hartwright<br><br>The investigation concluded at the end of the inquest on the 12th December 2025<br><br>The conclusion of the inquest was a narrative conclusion as follows:<br><br>Jake died at Queens Medical Centre on 17.1.25 from multiple organ failure, secondary to extensive bowel ischaemia, likely caused by an episode of gastroenteritis. This is a very unusual complication, and it is likely that his underlying lower large bowel condition made him more prone to bowel dilatation and bowel wall damage in the presence of infection.<br>There were opportunities missed on the morning of 16.1.25 to send an ambulance crew to assess Jake at home, which would have led to hospital transfer, likely by approximately 12.30 on that day.<br>Jake had a cardiac arrest at home at 15.05 on that day likely secondary to hypovolaemic shock, secondary to the established bowel ischaemia. His prolonged downtime and the bowel ischaemia led to multiple organ failure and to his death, in the early hours of 17.1.25.<br>There were serious issues of care on 16.1.25 - specifically the lack of a Category 2 ambulance being organised at 10.30 hours on 16.1.25 following a telephone assessment by the Nottingham Emergency Medical service (NEMS), but also issues across the urgent care pathway with the management of the Category 3 call, including with transfer of clinical information between the 111 service, East Midlands Ambulance Service and NEMS.<br>Whilst these issues are serious, it is not possible to say that on balance they have made a more than minimal, negligible or trivial contribution to Jake's death- bowel ischaemia is a serious and life threatening condition with a high risk of death. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Jake had a background history of chronic constipation, likely secondary to idiopathic megarectum and sigmoid, that is a dilated bowel of unknown cause. He had required a bowel resection and stoma in 2016 following a bowel perforation caused by stercoral ulceration (meaning bowel wall ulceration caused by hard faeces eroding into it). |

| | |
|---|---|
| | The stoma was reversed in 2017, and he managed reasonably with his bowel function thereafter. Around Christmas 2024 he began to struggle again with constipation, requiring laxatives again. He was seen at the Urgent Treatment Centre in Newark on 2.1.25, given an enema which helped him to pass some stool.<br><br>He then took further laxatives on 14.1.25, and severe vomiting and diarrhoea followed. His partner rang the 111 service at 09.16 on 16.1.25, and the assessment established that Jake had passed out an hour prior, that he had projectile vomiting and diarrhoea and was not keeping fluids down, that he had persistent abdominal pain, no energy, dizziness if he stood up to walk. His stomach was noted to be hard. The assessment did not capture the severity of his clinical condition, did not explore the passing out episode, nor the abdominal pain, despite his medical history being known.<br><br>The 111 Health Adviser (non- clinical) organised a clinical adviser from the 111 service to ring Jake back at 09.54 hours. This assessment identified the requirement for a Category 3 ambulance response, that is for an ambulance to be dispatched to assess Jake face to face, with a 90th percentile response time of 120 minutes. Whilst there were a number of red and amber flags for sepsis described to both the Health Adviser and the Clinical Adviser, they were not recognised as such. Had they been, it is possible that a Category 2 ambulance response (with a mean response time of 18 minutes, and 90th percentile response time of 40 minutes) would have been the outcome of this call.<br><br>The Category 3 request was sent to East Midlands Ambulance Service (EMAS) at 09.57 hours. Very limited information only (that is just what is in the problem field in the EMAS CAD form) was reviewed by the EMAS clinician, with no further review of other CAD information passed from 111. The EMAS clinical navigator cancelled the ambulance request, and transferred the call information to the Nottingham Emergency Medical Service for a telephone assessment. Had all the information regarding Jake's extensive systemic symptoms, strongly suggestive of sepsis, been noted, it is likely the EMAS clinician would have rung Jake herself rather than transferring the call. It is possible had she done so, that she would have recognised the seriousness of Jakes condition and upgraded the call to a Category 2 - this was another possible opportunity missed for conveyance to hospital at this time.<br><br>The NEMS call to Jake was made at 10.18 hours on 16.1.25. It was a poor assessment with lack of exploration of his symptoms of weakness, passing out, and fever. The severity of the abdominal pain and abdominal distension was not explored or understood, and therefore Jake was thought to have simple gastroenteritis. He was given advice and the case closed. Had the severity of his illness, that of sepsis with bowel ischaemia been understood, it is likely that a Category 2 disposition would have been reached and the request made to EMAS for automatic ambulance dispatch.<br><br>Jake went on to have a cardiac arrest later that afternoon. Whilst a return of circulation was achieved after 39 minutes, he remained critically unwell on arrival in the Emergency Department at Queens Medical Centre. He was too unstable for any surgical intervention to be offered, and sadly he continued to deteriorate. He died the following early morning. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows –<br><br>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<br>2. There remains detailed information in the EMAS 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.<br>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<br>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<br>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<br><br>I am not reassured that necessary actions to address these serious issues identified are in place. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>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.<br><br>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.<br><br>. |
| 8 | **COPIES and PUBLICATION**<br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>1. Mr Hartwright's family<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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. |