REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive Officer East Suffolk & North Essex NHS Trust**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 22nd July 2024 I commenced an investigation into the tragic death of- **Terrence FROST** The investigation concluded at the end of the inquest on 5th March 2026. The conclusion of the inquest was that:- **Terrence Frost, died as the result of natural causes** The medical cause of death was confirmed as: **1a Acute Pulmonary Oedema** **1b Cardiomegaly, Congestive Cardiac Failure** **1c Coronary Artery Disease, Systemic Atherosclerosis** **2 Sepsis of Uncertain Origin, Diabetes Mellitus (Type 2)**
4	**CIRCUMSTANCES OF THE DEATH** **Terrence Frost's death was verified at 00:26 on 18th July 2024, at the Ipswich Hospital, in Ipswich, Suffolk, although Terrence's death had occurred earlier at approximately 22:20 on 17th July 2024.** **On the 11th July 2024 Terrence was admitted to the Ipswich Hospital for an elective surgery (angioplasty) to improve the blood flow to his left leg and foot. Terrence was discharged on the following day 12th July 2024.** **On the 14th July 2024 Terrence was admitted again to the Ipswich Hospital with abdominal pain and rectal bleeding. No diagnosis was made, and as this settled spontaneously, Terrence was discharged again on the 15th July 2024.** **On the 16th July 2024, due to concerns raised by his family, a GP's Paramedic conducted a home visit, and following subsequent concerning blood test results Terrence was told to go back to Ipswich Hospital as a failed discharge.** **After a prolonged period in the Accident and Emergency department Terrence was readmitted to the Ipswich Hospital.**

	Despite testing, no definitive diagnosis was made during Terrence's final admission, and Terrence appeared reasonably stable until he suffered a sudden collapse and cardiac arrest at 21:22 on the 17th July 2024. A subsequent postmortem examination identified that Terrence suffered from significant cardiac disease (cardiomegaly and coronary artery disease) and significant vascular disease (systemic atherosclerosis). **The pathologist identified that his clinical markers identified that sepsis played a factor in Terrence's death, although evidence of any infection could not be found.**
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: **Evidence was heard that prior to his attendance in the Accident and Emergency department on the 16th July 2024, Terrence had been seen at home by a paramedic from his surgery, who was concerned by Terrence's presentation and wanted to admit him to hospital. However, Terrence was reluctant so it was agreed that urgent blood tests would be taken in the first instance.** **The results of these tests were seen by a GP, and due to the findings (which indicated a possible serious infection or inflammation) the GP called Terrence and told him to go straight to hospital, and whilst enroute she would speak to the Medical Assessment Unit.** **In evidence the GP said she then spent 30 minutes on the telephone trying to contact the Medical Assessment Unit as is the required procedure, to discuss Terrence's admission.** **After being unable to contact the Medical Assessment Unit, the GP contacted Terrence, via a family member, and told him that as she could not contact the Medical Assessment Unit he should head to the Accident and Emergency department instead. The GP told Terrence she would pre-alert the Accident and Emergency department to his arrival.** **The GP then spent a further period of time telephoning the Accident and Emergency department but again could not get through.** **As such upon arrival, a patient who was considered by their GP to be significantly unwell enough to warrant either admission to the Medical Assessment Unit, or that Accident and Emergency should be pre-alerted to their arrival, was unable to speak to either unit prior to the patient's arrival.** **Terrence endured a 5 hour wait in Accident and Emergency before being seen. Although observations taken at the time of his subsequent admission suggest he had not developed sepsis at this stage, I am concerned that the inability of a GP to be able to promptly communicate with either the Medical Assessment Unit or Accident and Emergency department may lead to future deaths in cases where suspected sepsis or other life threatening conditions have been differentially diagnosed, especially if those conditions have progressed further than Terrence's had at the time of his arrival.** **I am further concerned that evidence was heard from a clinician based at**

	the Ipswich Hospital itself, that they too found contacting the Medical Assessment Unit extremely difficult, with internal hospital telephone calls frequently going unanswered.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 04 May 2026 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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. Terrence's next of kin** I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated: 09/03/2026** [redacted] **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**