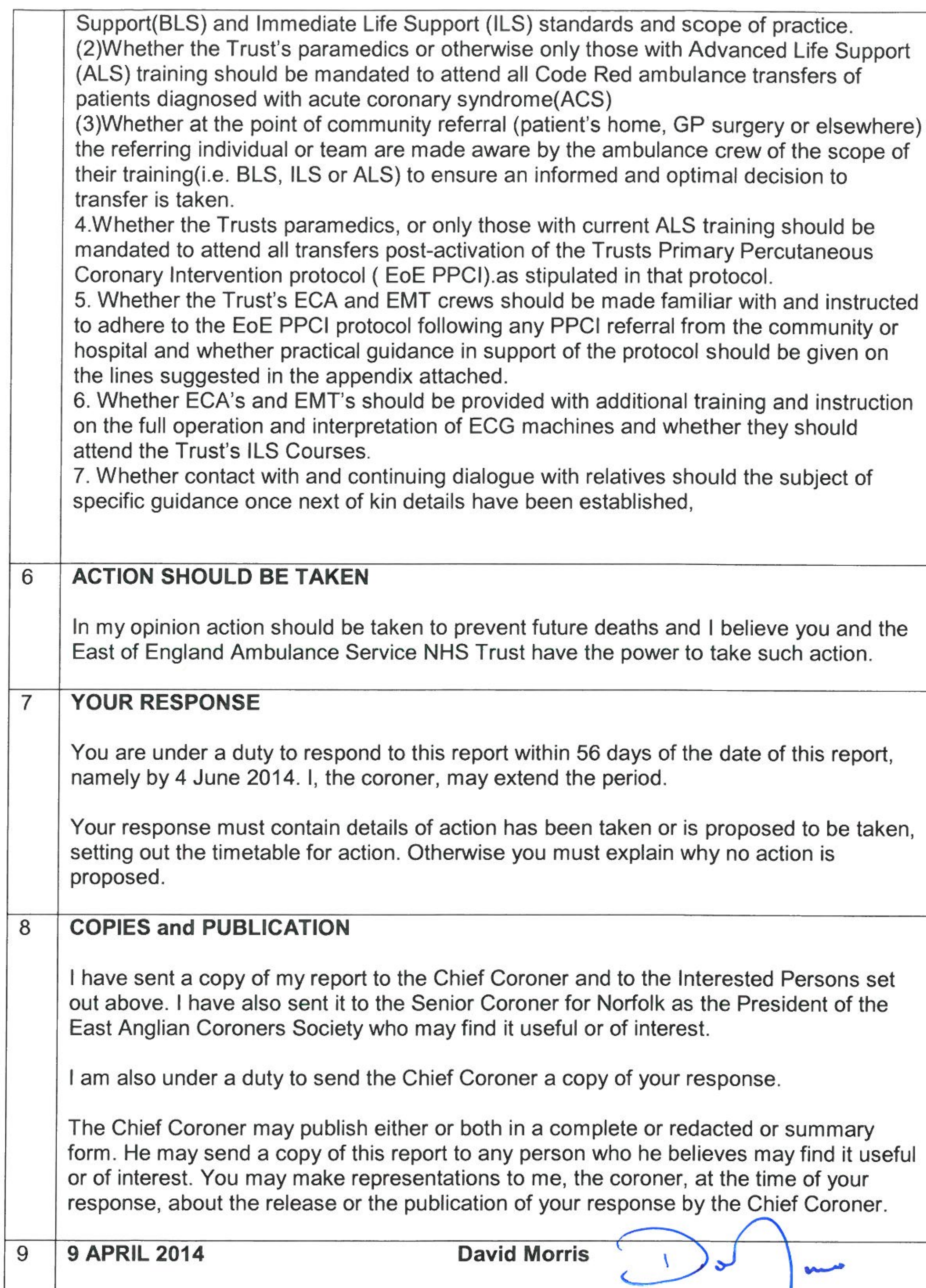
INQUEST INTO THE DEATH OF STEPHEN ANTHONY BEDFORD

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **(for the East of England Ambulance NHS Trust ("the Trust"))** 2. **Messrs StewartsLaw LLP (for the Family)** 3. **Messrs Hempsons (Solicitors for The Trust)** 4. **The Chief Coroner**
1	**CORONER** I am David Scott Morris, Senior Coroner for the coronial area of South and West Cambridgeshire
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 2 August 2012 I commenced an investigation into the death of Stephen Anthony BEDFORD, aged 33. The investigation concluded at the end of the Inquest on 11 July 2013. The Conclusion of the inquest, handed down on 31 October 2013, was that: Stephen Anthony Bedford died from a Natural Cause namely: 1a Acute Myocardial Ischaemia 1b Coronary Artery Thrombosis The outcome might have been different had he been transferred in a more timely manner to the nearby Specialist Coronary Intervention Centre
4	CIRCUMSTANCES OF THE DEATH Stephen Bedford aged 33 years had a past medical history of Type 1 Diabetes Mellitus and hypercholesterolemia. On 31.7.12 he experienced central chest pain whilst at a gym. En route home he attended Eaton Socon Health Centre where he collapsed at about 1600 hrs. An ambulance was called and he was conveyed to Bedford Hospital A&E where he was diagnosed with an ST elevation myocardial infarction. The same ambulance crew then conveyed him to Papworth Hospital via PPCI arriving at 1805 hrs with a history that he had arrested en route. Despite intervention death was confirmed at 1940 hrs the same day.
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) Whether the Trust's Emergency Care Assistants (ECA) and Emergency Medical Technicians (EMT) are assessed at intervals to ensure compliance with Basic Life



	Support(BLS) and Immediate Life Support (ILS) standards and scope of practice. (2)Whether the Trust's paramedics or otherwise only those with Advanced Life Support (ALS) training should be mandated to attend all Code Red ambulance transfers of patients diagnosed with acute coronary syndrome(ACS) (3)Whether at the point of community referral (patient's home, GP surgery or elsewhere) the referring individual or team are made aware by the ambulance crew of the scope of their training(i.e. BLS, ILS or ALS) to ensure an informed and optimal decision to transfer is taken. 4.Whether the Trusts paramedics, or only those with current ALS training should be mandated to attend all transfers post-activation of the Trusts Primary Percutaneous Coronary Intervention protocol (EoE PPCI).as stipulated in that protocol. 5. Whether the Trust's ECA and EMT crews should be made familiar with and instructed to adhere to the EoE PPCI protocol following any PPCI referral from the community or hospital and whether practical guidance in support of the protocol should be given on the lines suggested in the appendix attached. 6. Whether ECA's and EMT's should be provided with additional training and instruction on the full operation and interpretation of ECG machines and whether they should attend the Trust's ILS Courses. 7. Whether contact with and continuing dialogue with relatives should the subject of specific guidance once next of kin details have been established,
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and the East of England Ambulance Service NHS Trust 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 4 June 2014. I, the coroner, may extend the period. Your response must contain details of action has been taken or is 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 Interested Persons set out above. I have also sent it to the Senior Coroner for Norfolk as the President of the East Anglian Coroners Society who may find it useful or of interest. 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	**9 APRIL 2014** **David Morris**