Karen Dilks
Senior Coroner for the City of Newcastle upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **North East Ambulance Service NHS Foundation Trust Bernicia House Goldcrest Way Newburn Riverside Business Park Newcastle upon Tyne NE15 8NY**
1	**CORONER** I am Karen Dilks, Senior Coroner, for the coroner area of city of Newcastle upon Tyne
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 and http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24 April 2019 I opened an investigation into the death of Philip Richard Hayes aged 60yrs. The investigation concluded at the end of the inquest on 29 October 2019. The conclusion of the Inquest was: Medical cause of death: Aortic dissection

	Conclusion: Natural causes
4	**CIRCUMSTANCES OF THE DEATH** On 14 April 2019 in or around 13:13 Philip Hayes suffered an aortic dissection. Initial symptoms were chest and flank pain. At 13:13 a 999 call was made to summon urgent assistance. The call was triaged at 13:16 and categorised C2 response (18 minutes). At 13:23, 13:27, 13:31, 13:45 and 13:59 further calls reporting new symptoms and a deteriorating condition were made. These subsequent calls did not result in a reassessment of the original categorisation nor did the calls result in the case being referred for clinical input. Ambulance technicians arrived at 14:02 and paramedics at 14:15 (1 hour and 2 minutes after the original call). Philip Hayes was transported to the Northumbria Specialist Emergency Care Hospital, arriving at 15:13. His dissection was diagnosed following CT scan at approximately 23:56 when arrangements for his transfer to Freeman Hospital, Newcastle for specialist vascular care were made. Notwithstanding maximal care and treatment he died there on 18 April 2019
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. – (1) Delay in ambulance dispatch Call categorised C2 received response 1 hour 2 minutes after original call (2) Failure to conduct reassessment of C2 category notwithstanding 5 subsequent calls describing additional symptoms and a deteriorating condition (3) Inconsistency in approach and answers to algorithm question designed to indicate risk of aortic aneurysm/rupture/dissection

	(4) Calls triaged by health advisors with limited medical training and no medical qualifications (5) Inconsistency in approach to referral for clinical input (6) Appropriateness of triage by algorithm. Insufficient if any weight given to actual reported symptoms and indicators of a medical emergency
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 27 December 2019. 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: [redacted] NHS England 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	**30 October 2019** **Signed by Karen Dilks (Senior Coroner)**