	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **AACE – The Association of Ambulance Chief Executives** **NASMED – The National Ambulance Service Medical Directors**
1	**CORONER** I am Laurinda Bower, HM Assistant Coroner for **Nottingham City and 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17 April 2019, I commenced an investigation into the death of Maureen Woods. The investigation concluded at the end of an inquest, heard on 11 July 2019. The conclusion of the inquest was that Mrs Woods died as a result of natural causes from: 1a. Acute Left Ventricular Failure 1b. Anterior Myocardial Infarction 1c. Ischaemic and Hypertensive Heart Disease 2. Previous Myocardial Infarction and COPD
4	**CIRCUMSTANCES OF DEATH** Maureen Woods died on 26 January 2019 whilst a patient at the Emergency Department of Bassetlaw District General Hospital, Nottinghamshire. An ambulance was summoned by a concerned neighbour dialling 999 at 00.29 hours on 26 January 2019 to request assistance for Mrs Woods. It was reported that she was "half passed out", "had difficulty breathing", "had a tight chest", "looked pale, clammy and felt nauseous", and "had a history of heart attack". The 999 call was triaged in line with national protocol for a primary complaint of chest pain and graded as a category 2 response. Due to overwhelming demand on the ambulance service that night, the ambulance did not attend to Mrs Woods within the prescribed target time of 18 to 40 minutes for a category 2 call. At 0126 hours a further 999 call was made by the neighbour and Mrs Woods went into cardiac arrest during that call. Paramedics attended promptly but failed to administer Amiodarone contrary to National Resuscitation guidance and without good reason. The delay in dispatching an ambulance and the failure to administer medication represent failings that prevented Mrs Woods from having the best possible chance of survival. However, it cannot be concluded on a balance of probabilities that either of these failings have caused or contributed to her death. The evidence from the witnesses employed by EMAS confirmed that Mrs Woods was most likely suffering a cardiac event when the first call was made, but because she wasn't in cardiac arrest, the call was appropriately graded as a category 2 response, meaning that a resource should arrive with the patient

	within 18 to 40 minutes. Both EMAS witnesses agreed that 40 minutes appears too long to wait for an ambulance/solo responder when the complaint is chest related and most likely a cardiac event. The EMAS witnesses told me that the Trust were 'surprised' to see calls such as this being graded as category 2 when the new categorisation system for grading off calls was introduced nationally.
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) Patients requiring an emergency ambulance response reporting symptoms consistent with a cardiac event, but who are not yet in cardiac arrest, may wait up to 40 minutes for a category 2 response in line with the current national response times. (2) To combat this perceived inadequacy in nationally agreed response times, the East Midlands Ambulance Service NHS Trust has developed an adjunct to the protocol by triaging all non-category 1 calls to upgrade calls such as Mrs Woods for a priority response. However, resources do not permit each and every call to be triaged, and Mrs Wood's call was not triaged before she went into cardiac arrest. If the system for national response times is having to be supported by local adjuncts to the system, this rather suggests that the allocation of these calls in category 2 lies outside of clinical need.

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 action in relation to the above matters (1) I heard evidence that NASMED meet regularly to review the efficacy of the National response times and grading of calls. I wonder whether there could be a review of the grading of cardiac complaint calls within category 2 and whether this appropriately and safely meets clinical need.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 September 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] EMAS 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	24/07/2019 Signature_____ Laurinda Bower Assistant Coroner **Nottingham City and Nottinghamshire**