REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Secretary of State for Department of Health 2. Blackpool Clinical Commissioning Group (responsible for NWAS commissioning) 3. North West Ambulance Service (NWAS) 4. Chief Executives of all Manchester Hospitals
1	**CORONER** I am Ms Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 9th November 2018 I commenced an investigation into the death of **William Oliver.**
4	**CIRCUMSTANCES OF DEATH** Mr Oliver died on the 1st November 2018 at his home address, [redacted] His medical cause of death was confirmed as 1a) Hypovolaemic Shock 1b) Retroperitoneal Haematoma 1c) Ruptured Abdominal Aortic Aneurysm 2) Atherosclerosis. The Court heard how Mr Oliver, who lived alone in supported accommodation, became acutely unwell in the early hours of the morning on the 1st November. An emergency call was placed to NWAS at 06:00 hrs by Anchorcall (the emergency care support service). Of note they were not physically present with Mr Oliver. From the information provided they informed NWAS that Mr Oliver thought he may have had two strokes during the night and that he thought he had fractured his hip. In addition he was struggling to breathe and was sweating. The call was graded as requiring a Category 3 response. Subsequent telephone calls at 06:26 hrs (between NWAS and Mr Oliver) and 06:44 (between Anchorcall and NWAS) were dealt with inappropriately and Mr Oliver's deteriorating condition was not re-triaged. The Court found on the balance of probabilities that the response would have been increased to at least a Category 2 response. At 07:44 hrs a further call was received from Anchorcall who by this time could not make contact with Mr Oliver and the call was escalated at 07.50hrs. At 07.51 an emergency ambulance was allocated and arrived on scene at 08.05 when Mr Oliver was found deceased.
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. Meal Break Policy and Shift Rostering During the course of the Inquest the Court heard evidence as to the demand placed on NWAS during the night of the 31st October – 1st November. Difficulties in allocating resources within the Manchester area of the North West that night had been escalated to the Regional Control and Command Centre. One of the reasons for difficulties in allocating resources was directly attributed to the Meal Break Policy. In short, the issue being that each crew has to take a 30 minute meal break within their meal break window (this being three hours after their shift starts). If the crews reach the end of their meal break window without having taken a break they are automatically stood down and are unavailable to allocate calls to. The consequences of this policy have also been highlighted in other investigations following a death. In this case there was a significant reduction in the number of vehicles able to be allocated during the time Mr Oliver had contacted NWAS. The Court heard evidence this policy has been under review for sometime and consideration has been given to staggering the shift start times, but as yet no changes have been implemented 2. Turnaround times at Greater Manchester Hospitals Another contributing factor to the decreased availability of ambulances on the 31st October - 1st November 2018 was the turnaround times from hospitals in the Greater Manchester area. This was greater than anticipated at numerous sites. Whilst all hospitals were busy the turnaround times at Manchester Royal Infirmary, North Manchester General hospital, Royal Oldham, Salford Royal and Stepping Hill hospital were all particularly higher than anticipated with numerous ambulances delayed for over one hour. In total from the commencement of the night shift on the 31st October more than 273 hours of ambulance availability were spent at hospital sites handing over patients. The evidence from NWAS did not suggest this was significantly different to other nights or uncommon.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 27th November 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 namely:- 1. Family of Mr Oliver 2. NWAS 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 from. 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	Date: 12th September 2019 Signed: