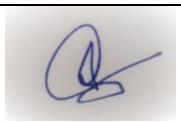
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chief Executive, NHS England NHS England, PO Box 16738, Redditch, B97 9PT. 2. The CEO, NHS Stockport Clinical Commissioning Group, 4th Floor, Stopford House, Stockport SK1 3XE.
1	**CORONER** I am Andrew Bridgman, Assistant Coroner, for the coroner area of Manchester South.
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 25.11.19 an investigation commenced into the death of Martin Keith Sullivan who died on 24.11.19, aged 15 years. The investigation concluded on 27.01.21. The medical cause of death was **1a Multiple organ failure** The conclusion was Natural causes. Martin's death could possibly have been averted had he received medical attention. The opportunity for Martin to receive such attention was denied by reason of, a) the failure of the MPDS algorithm and/or call handler script to identify the severity of Martin's condition as life-threatening and needing a Category 1 response, i. probably on the first 999 call ii. certainly, on the second 999 call b) the inability that morning for NWAS to meet Category 2 response times c) a (policy) failure for the NWAS EMD call handler to enquire as to the possibility of taking Martin direct to hospital on both 999 calls.
4	**CIRCUMSTANCES OF THE DEATH** Martin was born on 29 July 2004. Martin was diagnosed with asthma in 2009 – so aged 5 years. His condition was well controlled by his GP practice. It did not interfere with his life. In 2013 he was admitted overnight following an acute exacerbation. In 2016 Martin suffered another acute episode, he attended A&E – was stabilised and

	discharged home the same day. The events leading to Martin's death began at about 5.50am on 24.11.19 when Martin was woken by difficulty in breathing – an indication on the evidence of a Paediatric Consultant that this was a severe attack. Martin was unable to control this with his Ventolin inhaler and woke up his father at about at 6.00am. They continued to try to manage the asthma attack with the Ventolin inhaler. At 06.16am Martin's father called 999. The EMD followed the MPDS script and Martin was prioritised as Category 2; as Martin was breathing (described by his father as breathing heavy) and alert. Martin entered Category 2 on the answer that he had difficulty breathing between sentences. Again, the Paediatric evidence was that this was indicative of a severe attack. The EMD was told that Martin's inhalers were not helping. Martin was also clammy – which in addition to the description of breathing description was indicative of a greater degree of severity. At that time there were 39 unallocated Category 2 calls. Martin's father was <u>not</u> told that the service was very busy; he was not asked about the possibility of taking Martin to hospital. Martin's condition worsened. Martin's father re-called 999 at 06.33am. The script was followed again. Martin was again prioritised as Category 2. On this occasion Martin's father was told that the service was extremely busy; he was not asked about the possibility of taking Martin to hospital. After about 15-20 minutes (some 30-35 minutes from the first 999 call) Martin's father decided that he could no longer wait for the ambulance. At about 6.50am he drove Martin the short 10 minutes journey to Tameside General Hospital. As they arrived at the hospital Martin became unresponsive. Martin was admitted immediately from the car to the A&E resuscitation room at about 7.00am. CPR was commenced and all attempts at resuscitation continued until 8.23am. Martin was certified dead at 8.23am on 24.11.19.
5	**<u>CORONER'S CONCERNS</u>** 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. The MPDS script and algorithm, it seems, were inadequate in this instance to recognise the life-threatening situation that Martin was in. On the Paediatric evidence this acute attack was only going to end in one way without medical intervention. The evidence before me was that delay in treatment is the main cause of asthma deaths in children. The algorithm does not account for the cumulative effect of more than one symptom. In this instance; difficulty breathing between sentences, clammy/sweaty and changes in colour. The Paediatric evidence was that these symptoms in a well-controlled asthmatic whose home remedies are not working are indicative of a severe and life threatening condition. 2. Rule 6 of the MPDS Protocol recognises that asthma patients are generally very experienced in managing their disease. Noting that statements such as can't breathe and unable to breathe or **a similar description** should be considered as

	ineffective breathing. Ineffective breathing eliciting a Category 1 response. It is not clear whether this requires a direct question from the EMD or whether it falls into the volunteered category of factors. There was no direct question from the EMD in this case. Given the significance of breathing problems in an asthma attack, and the inevitable progression without intervention, it is imperative in my view that the script seeks more detail and should not rely on information being 'volunteered'. 3. This was clearly a busy shift for NWAS, notwithstanding that the service was at 97% of commissioned capacity. 111 ambulances instead of 112 – having increased from 67 circa one hour previously, and it is likely that crisis was probably building from the reduced numbers of ambulance over the earlier period. The EA that eventually arrived was outside the 90th percentile target of 40mins. There is a clear history of NWAS being unable to meet NHS Cat 2 target times, in particular during Qs 3 & 4. NWAS Annual reports 2018/19 Yearly Category 2 targets: mean - 24.14mins and 90% - 52.31, with increased times for Qs 3&4. The Category 1,3 &4 targets are generally well met. 2019/20 Yearly Category 2 targets: mean – 26 mins and 90% - 56.27 mins, with increased times for Qs 3&4. The Category 1,3 &4 targets are generally well met. I understand that resource funding was applied for in November 19 and has been utilised from February 2020. 4. The identified policy failure as at 3c) above is being dealt with separately with NWAS.
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 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 27.04.2021. 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, [redacted], parents of Martin Sullivan North West Ambulance Service 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	 **02/03/2021** **Andrew Bridgman** **Assistant Coroner**