REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health and Social Care**
1	**CORONER** I am Lauren Costello, 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 12th July 2021 I commenced an investigation into the death of JOHN SCOTT MURPHY then aged 46 years. The investigation concluded at the end of the inquest on 21st April 2022. The conclusion of the inquest was natural causes. The medical cause of death being 1a Covid-19 Pneumonitis II Hypertensive Heart disease.

4	**CIRCUMSTANCES OF THE DEATH** John Murphy tested positive for Covid-19 infection in the week before he died. His family reported that he seemed to be improving although he was extremely fatigued. He lived alone and was alone in his home when he started to deteriorate in the early hours of Sunday 11th July 2021. At 03:20 he called the North West Ambulance Service and he reported that he was breathing too fast. The Service were dealing with extremely high demand at that time and had escalated its Patient Safety Plan response to Level 4, Tier 5. Mr Murphy was categorised as a category 2 patient needing emergency care. An ambulance arrived at his property at 05:21 and by that time he had passed away. A post-mortem examination confirmed that he had undiagnosed hypertensive heart disease which can be a risk factor for a poorer outcome with COVID 19. A number of measures have been undertaken by the North West Ambulance to address emergency response times including: • Utilising the Voluntary Aid Service and private ambulance support, • Ongoing recruitment, although it is acknowledged that this takes time, • The introduction of a Clinical assessment of category 3 cases rather than automatic ambulance allocation, • Movement to NHS pathway tool from MPDS which changes the way Category 3 and 4 calls are managed again to reduce ambulance allocation. Live waiting times in Greater Manchester during the Inquest hearing were on average at 34 minutes against a target of 18 minutes and in 9 out of 10 calls the response time was 1 hour 29 minutes against a target of 40 minutes.
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) Despite a number of measures being undertaken by the North West Ambulance Service, the delay in paramedics attending Category 2 calls has not been resolved to within target ranges because there are residual staff and emergency vehicle shortages. (2) The resources available in the North West Ambulance Service cannot be fully utilised because of the delays in ambulances clearing Accident and Emergency departments caused by the pressure on these departments across the NHS.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 23rd June 2022. 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] North West Ambulance Service I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. 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.
9	**DATE** **SIGNED BY CORONER** L. Costello **22nd April 2022**