	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** NHS Digital **2.** Department for Health and Social Care
1	**CORONER** I am Katrina Hepburn, Area Coroner, for the coroner area of Central & South East Kent
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 6th January 2020 I commenced an investigation into the death of Daniel Robert Ludlam, 49. The investigation concluded at the end of the inquest on 26th May 2022. The conclusion of the inquest was death due to natural causes, contributed to by neglect.

4	**CIRCUMSTANCES OF THE DEATH** Daniel Ludlam had a history of moderate learning disability and had a package of care in place. Daniel had a hiatus hernia and despite hospital attendances earlier in the year presenting with gastrointestinal symptoms, this had not been investigated thoroughly. As a result, the severity of his underlying gastric condition was not known. On the 30th December 2019, Daniel complained of gastrointestinal symptoms of abdominal pain, haematemesis and melena. There was an initial delay in an ambulance being requested by his carers. During the initial call to the emergency services, Daniel had been too unwell to speak with the call handler on the telephone. He was in bed and the land line telephone was in another room. It was clearly stated to the call handler by the carer that due to Daniel's learning disability, he may answer the questions with the response that he thought the questioner would want to hear, and that he may not answer the question accurately for that reason. Further, that he may not understand the question being asked. The carers assisted the call handler with relaying responses to the triage questions. The triage category allocated was Category 3 on the NHS Pathways triage system, with a response time of up to 2 hours. There was then a second call due to worsening symptoms and a further triage. The same information was relayed to a second call handler, that Daniel would not be able to answer the questions accurately due to his learning disability. The category remained at C3. There was a delay in paramedic arrival at the property, due to the Surge Level the service faced at the time. Further backup paramedic support was immediately required as Daniel's condition had deteriorated significantly. The category was changed to C2 and then C1. Despite the intervention of the paramedics, Daniel died at the scene. Post-mortem examination has identified that the hiatus hernia had been obstructed and caused a gastrointestinal haemorrhage which resulted in hypovolemic shock which was the medical cause of Daniel's death.

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) The NHS Pathways triage system for the calls that were made did not appear to take specific account of the patient who had a learning disability. Daniel could not communicate accurately his symptoms, and specifically would give the responses that he felt the call handler wanted to hear. He could not understand the questions being asked during the NHS Pathways triage. (2) There appears to be no procedure or specific protocol in place to deal with a caller with learning disabilities, save for an early exit from the triage Pathway to request a clinician review. I am concerned that in similar future cases, either the information being given will not result in the correct triage category being reached, or any exit from the pathway to seek clinician input may result in a delay in sending out a paramedic crew. (3) The carer assisting Daniel had to interpret the questions from the call handler in a way that Daniel could easily understand and then relay the responses back. In the future a call may come in from someone with learning disabilities who does not have a carer present to assist with the interpretation of the questions and to advocate on their behalf. Without there being a policy in place to deal with callers who cannot easily communicate or understand the questions, there is a risk of future death which could occur.
6	**ACTION SHOULD BE TAKEN** I understand that NHS Pathways telephone triage system is a clinical decision support system (CDSS) supporting the remote assessment of callers to urgent and emergency services. The system is owned by the Department and Health and Social Care, but is delivered by NHS Digital. I consider that together or individually you would have the ability to make any changes to the triage system. In my opinion action should be taken to prevent future deaths and I believe you and your organisations 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 18 July 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 South East Coast Ambulance Service, [redacted] 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. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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	7TH June 2022