REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: 1). Sajid Javid MP, Secretary of State for Health and Social Care

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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

INVESTIGATION and INQUEST

On 3rd February 2022, I opened an inquest into the death of Grenville Wait who died on 6th November 2021 at home, aged 83 years. The investigation concluded with an inquest which I heard on 22nd June 2022, and which concluded that Mr Wait had died as the consequence of an accident.

CIRCUMSTANCES OF THE DEATH

Mr Wait fell whilst out shopping on 2nd November 2021. He was taken to hospital where a fractured sternum was diagnosed. Mr Wait was discharged home with advice about taking regular analgesia and a plan to follow-up with a fracture clinic appointment.

On 6th November 2021, a family member found Mr Wait deeply unconscious in bed with altered breathing. A 999 call was made, and an emergency ambulance dispatched by way of a category 2 response, the call having been incorrectly coded as a category 2 rather than a category 1 call.

The ambulance arrived around 70 minutes after the time of the original 999 call, outside of the target range for category 2 calls.

Around the time of the ambulance crew's arrival, Mr Wait went into cardiac arrest and could not be resuscitated. A post mortem examination determined Mr Wait died as a consequence of:-

1a) Pneumonia on background of fractured sternum

2) Ischaemic heart disease.

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 **MATTER OF CONCERN** is as follows. –

1) Notwithstanding the steps North West Ambulance Service NHS Foundation Trust has taken via its patient safety plan to manage and respond to demands on its service, it is a matter of concern that target response times are still routinely not being met nationally. By way of illustration, the court heard evidence that on 21st June 2021, the Trust's average response time for a category 2 call was 50 minutes with the response time to 90% of all relevant incidents of 1 hour and 48 minutes.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **19th August 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of the family.

I have sent a copy of my report to the Care Quality Commission, 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.

Dated: 24th June 2022

Signature: Chris Morris HM

Area Coroner, Manchester South.