REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater 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 30th September 2021 I commenced an investigation into the death of Keith Hopwood. The investigation concluded on the 17th May 2022 and the conclusion was one of**: Narrative: Died from a myocardial infarction whilst awaiting the arrival of an ambulance**. The medical cause of death was **1a) Myocardial Infarction; 1b) Stenotic Coronary Artery Atheroma; and II) Hypertension, Diabetes Mellitus**
4	CIRCUMSTANCES OF THE DEATH On 29th September 2021 at 11:28 Keith Hopwood called an ambulance as he had fainted and felt very unwell. His call was assessed at a category 3. An ambulance was dispatched to his home address at 11:38. It was rerouted to a more urgent call at 11:43. At 12:50 Keith Hopwood was spoken to by a clinician. He reported chest pains and feeling very unwell. The call was suddenly disconnected. Mr Hopwood should have been upgraded to a category 2 but was not. A private ambulance under contract to NWAS was dispatched at 13:17 and arrived at 13:34 at his home address [redacted]. Keith Hopwood was unresponsive and could not be resuscitated. Post mortem examination found he had died from a myocardial infarction due to stenotic coronary artery atheroma.

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. The inquest heard that the delays in relation to the ambulance service were due to significant resource issues for all ambulance services not just North West Ambulance Service. The inquest was told that the shortages were due to staffing levels and demand. Steps had been taken to try to increase resources but the ambulance service was still struggling to meet the demand. In this case it was clear that had the initial ambulance not have been rerouted due to demand and pressure on services that he would have been alive when he was seen and have been transported to hospital; 2. The inquest heard that in the initial call to the ambulance service he was told to call back if he got worse in any way. His response was to say that he couldn't feel any worse than he had in the last 10 minutes. The algorithm driving the conversation did not direct that this response should require exploration of symptoms and why he had made this comment. As a consequence an opportunity to explore his presentation further was lost; 3. The ambulance that arrived was a private ambulance and not equipped to deal with a cardiac patient. If the second call had been correctly categorised it would not have been dispatched as private ambulances are deployed with less qualified staff to calls categorised as 3 and 4 due to a lack of NHS Ambulance resources. As a consequence a further ambulance had to be deployed to the scene when Mr Hopwood was found to be unresponsive; 4. The second call from Mr Hopwood disconnected. Because he was alone a disconnection does not automatically result in an escalation of a call. Had he been with someone who said he had become unresponsive that would have generated a different approach.
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 10th 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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely 1) [redacted] on behalf of the family; 2) 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	**Alison Mutch OBE** **HM Senior Coroner**  **15.06.22**