REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health and Social Care** **2. The Chief Executive of NHS England** **3. The Managing Director of the Association of Ambulance Chief Executives**
1	**CORONER** I am Claire Welch, Area Coroner for the coroner area of Cheshire.
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 7 January 2022 I commenced an investigation into the death of Charles Stephen Rothwell, who died on 6 January 2022 aged 69. The investigation concluded at the end of an inquest on 4 October 2022. The medical cause of death was 1a Lobar pneumonia and my conclusion was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Charles Rothwell had a telephone consultation with his GP on 5 January 2022 and was diagnosed with a chest infection and prescribed oral antibiotics. During the afternoon of 6 January his condition significantly deteriorated. In a 999 call made by staff to the North West Ambulance Service at 16.26h on 6 January he was correctly triaged as a Category 3, which should have resulted in attendance within 120 minutes but he was advised that there was likely to be a minimum 11 hour wait. In a second 999 call at 1726h he was again graded as Category 3 but reminded of the 11 hour wait. In a third 999 call at 1905h he was now coughing up blood and struggling to breath so was re-graded to Category 2. At the final 999 call at 1930h he was no longer breathing and was re-graded as Category 1. An ambulance arrived at 1937 but paramedics were unable to resuscitate Mr Rothwell. The reason for the non-attendance was that demand for emergency paramedic response significantly outstripped supply. Although I concluded that the delayed arrival of paramedics did not cause or contribute to the death, it is my opinion that ongoing lack of resources means there is a risk that future deaths will occur unless action is taken.
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) NWAS have developed a new triage system and have adopted NHS Pathways, which means that the initial call would now be triaged as Category 1 or 2. However, the problem of demand outstripping supply remains, such that if the same 999 call were made today the outcome would be the same. 2) NWAS continues to experience *"exceptionally high demand"* with the effect that *"the demand completely outstrips the capability* [they] *have got."* 3) By way of example, I was told that yesterday afternoon Category 2 responses (which should attract attendance within 18 minutes) were sitting at an average of 75 minutes, Category 3 responses (which should attract attendance within 120 minutes) were sitting at an average of 10.5h and category 4 responses (which should prompt a further telephone assessment within 90 – 180 minutes) were sitting at an average of 11.5h. 4) With the approach of winter NWAS are also beginning to see an even greater increase in demand on top of the existing demand. 5) The problem is not due to a shortage of NWAS ambulances or staff but instead is the result of a wider issue linked to the lack of resources in primary, secondary and social care. This results in demand for ambulances outstripping supply and a backlog of ambulances waiting to handover patients at A&E departments because of a shortage of A&E beds, which in turn is because of a shortage of hospital beds, which in turn is because of shortages in social care.
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 30 November 2022. I, the Area 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, [redacted] and the legal representative for the NWAS. 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	**5 October 2022**