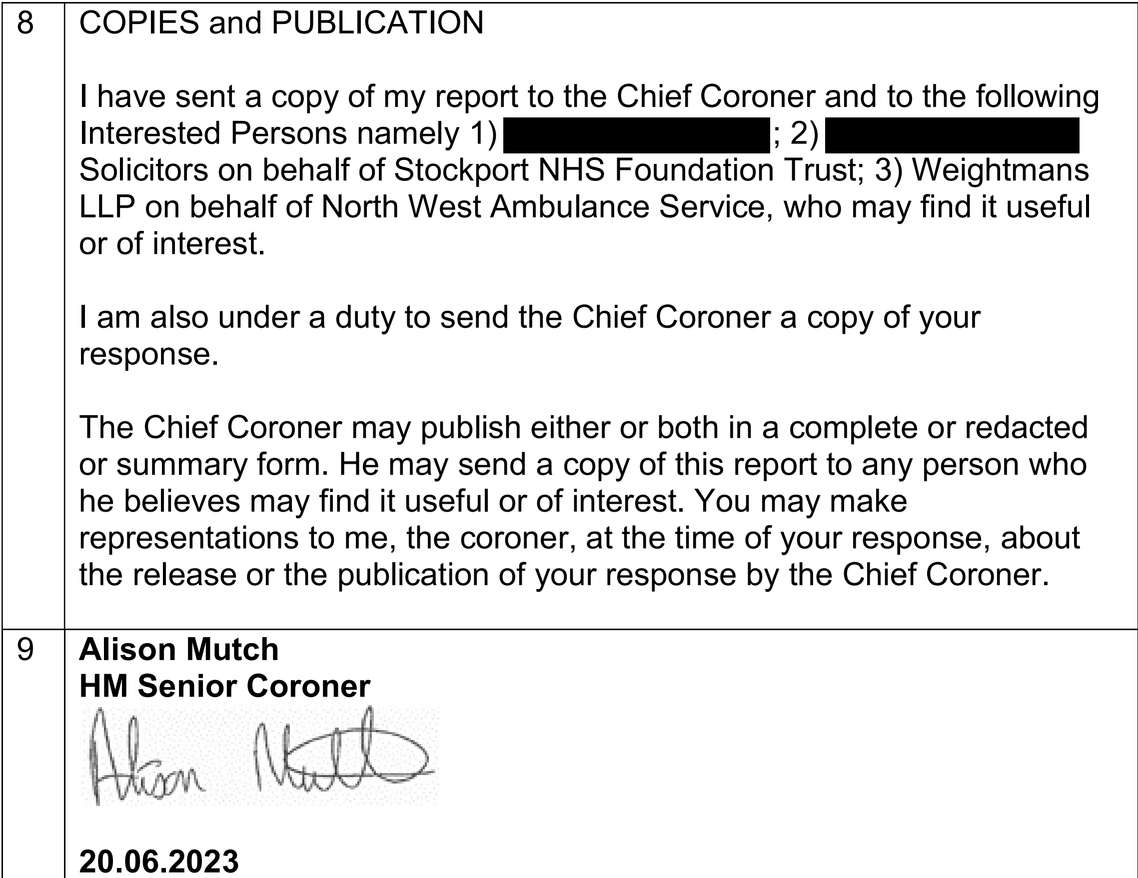
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The 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 19th December 2022 I commenced an investigation into the death of Joan Mary Corcoran. The investigation concluded on the 15th May 2023 and the conclusion was one of **Narrative: Died from complications of heart failure whilst being transported to hospital for treatment contributed to by the complications of an accidental fall.** The medical cause of death was **1a) Myocardial Infarction 1b) Heart Failure 1c) Hypertension II) Neck of femur fracture (operated on)**
4	CIRCUMSTANCES OF THE DEATH Joan Mary Corcoran had an accidental fall. She was operated on for a fracture to the neck of femur. Post-operatively she developed pneumonia. Subsequently the wound became infected, and a wound wash and debridement took place. She became increasingly frail. She was discharged home with support from the discharge to assess team. She felt unwell on 13th December 2022 and called for an ambulance with chest pains. Her initial call was dealt with as a category 5 call, and she contacted her GP. Her GP visited her and was concerned about her presentation. A further call to the ambulance service resulted in her being classified as a category 2 call. The blood tests taken indicated she was in severe heart failure and at a risk of a myocardial infarction. The ambulance arrived significantly outside the target Department of Health response times. The ambulance crew identified she needed urgent cardiac treatment and she was for transfer to hospital. Enroute to hospital she deteriorated further and died in the ambulance from complications of heart failure.

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. – The inquest heard evidence that under the Department of Health's Ambulance Response time criteria, a category 2 call should have an average response time of 18 minutes and be within 40 minutes in 9 out of 10 cases. The evidence before the inquest was that in her case the response time on the category 2 call was 1 hour and 5 minutes - significantly outside the target time. A response within the target time would have meant that she would not have deteriorated and died in the ambulance. She would have been in a hospital with access to treatment available in such a setting. The evidence before the inquest was that her case was not a one off and delays of this nature had been occurring throughout the day. The mean time for Category 2 response times that day was 1 hour and 22 minutes and the 90th percentile was just over 3 hours. At 17.58 that day there were 142 emergencies waiting in Greater Manchester alone and 430 across the North West. The average response time at that point for Category 2 patients was 2 hours and 33 minutes. The inquest heard that the cause of these significant delays in patients receiving care in a timely manner was multifactorial and included the demand for ambulances across Greater Manchester and the North West and the long ambulance delays at A and E departments due to the demand on A and E services.
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 15th August 2023. 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]; 2) [redacted] Solicitors on behalf of Stockport NHS Foundation Trust; 3) Weightmans LLP on behalf of 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** **HM Senior Coroner** **20.06.2023**