Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO: NHS Pathways, care of the Department for Health and Social Care.**
1	**CORONER** I am Victoria Davies, 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 08 September 2022 I commenced an investigation into the death of Glyn ACKERLEY aged 56. The investigation concluded at the end of the inquest on 22 November 2022. The conclusion of the inquest was that: Glyn Ackerley died after becoming unresponsive at home on 4 September 2022, the cause of which cannot be determined.
4	**CIRCUMSTANCES OF THE DEATH** Glyn Ackerley had a number of health issues which necessitated him taking pain relieving medication including [redacted]. On 4 September 2022 he reported to his wife that he had swallowed [redacted] and left the address. His wife telephoned for an ambulance (North West Ambulance Service) at 21.48 and the call was triaged as a category 3 response based on the NHS Pathways algorithm. At 22.37 the police called the ambulance service and advised that he was having difficulty breathing. The call was upgraded to a category 1 response and the ambulance arrived at 22.52 The evidence was inconclusive as to whether Mr Ackerley had in fact swallowed [redacted] as he reported to his wife, with levels of [redacted] found in his blood post mortem being consistent with both an overdose and the therapeutic range.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The current NHS Pathways process does not differentiate between a high risk and low risk overdose, categorising all such calls without additional symptoms as category 3. Evidence was heard during the inquest that time is of the essence when dealing with an opiate overdose, and giving reversal medication prior to any respiratory depression or cardiac arrest will likely have a better outcome. In light of the concerns raised by this case, NWAS

	have reviewed their process and added in additional questions for call handlers to identity high risk medications involved in an overdose, which they then automatically categorise as a category 2 and send for a call back from a clinician immediately. NWAS gave evidence in writing that they had raised the concern and their suggested management with the National NHS Pathways team on 6 April 2023, with the result that the national team would continue to review the process but with clinical review in 15 minutes and high risk medications being upgraded to category 2. It is unclear from the evidence whether this is a proposed change to the process in place in September 2022 which would mean Mr Ackerley would have had a category 2 response at 21.48, or whether the system remains the same. If the system is not for a category 2 response for high risk medication, it is my concern that this will not allow for prompt treatment of those who have taken a potentially fatal overdose.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 January 17, 2024. 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: Mr Ackerley's family I have also sent it to North West Ambulance Service NHS Trust who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 27/11/2023** V Davies **Victoria DAVIES** **Area Coroner for** **Cheshire**