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 South Manchester
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 6th June 2023 I commenced an investigation into the death of Joseph Michael Miller. The investigation concluded on the 2nd February 2023 and the conclusion was one of **narrative: Died from the complications of a seizure contributed to by the use of cocaine.** The medical cause of death was **1a) Hypoxic Brain Injury 1b) Cardiac Arrest on the background of a seizure and cocaine use**
4	CIRCUMSTANCES OF THE DEATH On the 31st May 2023, Joseph Michael Miller was seen by a neighbour to be fitting in the garden of his home address. A call was made to the ambulance service that was initially categorised as category 1 but downgraded to category 3 when it was reported that he was no longer fitting. A further call was made when he had another seizure and became unconscious. Ambulance crews attended. The initial Rapid Response Team were there within eight minutes. He did not return to consciousness despite extensive efforts to resuscitate him. He was transferred to Tameside General Hospital where tests on the 3rd June confirmed severe hypoxic brain injury and he was declared dead on 5th June.

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 evidence that different ambulance services use different pathways that can impact how calls are categorised /downgraded. The consequence of this is that how the ambulance services across England deal with a call varies depending on where you live. As an example in this inquest, because of where Joseph lived, calls can go to EMAS or NWAS depending on which mobile telephone mast the call pings on. The initial call went to EMAS who on being told he was no longer fitting downgraded the call, in line with their pathway. The inquest was told that had the call been dealt with by NWAS they would not have downgraded the call to a category 3 in this situation because that was not how their pathway operated. 2. The consequence of these different pathways is that there is not a consistent approach to call categorisation across the country which can have a significant impact on the dispatch of potentially lifesaving attendance by the ambulance service.
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 9th May 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 namely [redacted] on behalf of the Family, 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**  **14.03.2024**