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 Lauren Costello, Assistant 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 23rd October 2023 I commenced an investigation into the death of Peter Beresford, then aged 65 years. The investigation concluded at the end of the inquest on 23rd February 2024. The conclusion of the inquest was a narrative conclusion that Mr Beresford died as a result of acute myocardial ischaemia precipitated by coronary thrombosis as a consequence of atherosclerosis against a background of high blood pressure and high cholesterol. The medical cause of death being: 1 (a) Acute myocardial ischaemia (b) Coronary thrombosis (c) Coronary atherosclerosis
4	CIRCUMSTANCES OF THE DEATH Peter Beresford suffered from high cholesterol and high blood pressure which both increase the risk of ischaemic heart disease. On 25th September 2023, Mr Beresford contacted the North West Ambulance Service complaining of chest pain at 05:38. His call was prioritised appropriately as a Category 2 call. When an ambulance arrived at his home address at 07:14 he was already deceased. The average response standard for Category 2 calls is within 18 minutes and attendance is within 40 minutes nine out of ten times. A post-mortem examination revealed that Mr Beresford died as a result of acute myocardial ischaemia precipitated by coronary thrombosis as a

	consequence of coronary atherosclerosis. The Inquest heard that the North West Ambulance Service was unable to meet average response standards due to resourcing levels and the fact that ambulances were unable to clear the region's hospitals because of the long waiting times there. A level 2 incident plan was commenced as a result. A number of measures have been undertaken by the North West Ambulance Service to address emergency response times including: • Ongoing recruitment, • The introduction of a Clinical assessment of category 3 cases rather than automatic ambulance allocation, • Introduction of Hospital Ambulance Liaison Offers to assist ambulances to clear hospitals and reduce waiting time. The inquest heard that waiting times across the North West region are still impacted by peaks in demand and problems clearing the regions hospitals despite the above measures.
5	<u>CORONER'S CONCERNS</u> 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) Despite a number of measures being undertaken by the North West Ambulance Service, the delay in paramedics attending Category 2 calls has not been resolved to within target ranges because there are residual staff and emergency vehicle shortages. (2) The resources available in the North West Ambulance Service cannot be fully utilised because of the delays in ambulances clearing Accident and Emergency departments caused by the pressure on these departments across the NHS.
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 7th 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 1) [redacted] on behalf of the Family and; 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	**Lauren Costello** **HM Assistant Coroner** L. Costello **12.03.2024**