REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health and Social Care**
1	**CORONER** I am Lauren Costello, Assistant Coroner, for the Coroner Area of 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 24th May 2023 an investigation was commenced into the death of Bobilya Mulonge then aged 62 years. The investigation concluded at the end of the inquest on 19th April 2024. The conclusion of the inquest was a narrative **conclusion that Mrs Mulonge died as a result of congestive cardiac failure against a background of hypertensive heart disease. Ambulance response times probably contributed to her death.** The medical cause of death being: 1 (a) Congestive Cardiac Failure (b) Hypertensive Heart Disease II) Chronic Kidney disease and Type II diabetes mellitus

4	**CIRCUMSTANCES OF THE DEATH** Mrs Mulonge had multiple co-morbidities including hypertension with a history of hypertensive crisis, stroke, diabetes and she had multiple hospital admissions in 2022. On 24 November 2022 at 06:09 an ambulance was called because her breathing was laboured, and her consciousness was reducing. During the call she became unconscious. When an ambulance arrived 72 minutes later, at 07:24, she was in cardiac arrest. Her heart was restarted but despite appropriate treatment she continued to deteriorate and died at 10:45 on 24 November 2022 at Tameside General Hospital, as a result of congestive cardiac failure against a background of hypertensive heart disease, chronic kidney disease and type II diabetes mellitus. The Inquest heard that the North West Ambulance Service was unable to meet average response standards at the time of the 999 call mainly due to the fact that ambulances were unable to clear the region's hospitals because of the long waiting times there. In addition, there were high call volumes. A level 4 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: • Regular meetings take place between the North West Ambulance Service and NHS Trusts in the region to discuss the delays at a regional level. • There are faster communications between senior leaders in the North West Ambulance Service and NHS Trusts when there is a period of high demand or delay. • North West Ambulance Service managers are deployed to struggling Accident and Emergency departments. • A delayed handover checklist is in place. • Patients are triaged to assess if they can wait in a waiting room to release ambulances – this is called Fit to Sit. • Patients who can be safely grouped with other patients and looked after by one ambulance crew rather than in individual ambulances are placed together to release ambulances. • The North West Ambulance Service now has an option to remove crews with 15 minutes notice to the hospital. • Batch Divert is in place which allows the North West Ambulance Service to send an ambulance to another hospital. The inquest heard that waiting times across the North West region are still impacted by problems clearing the regions hospitals despite the above measures.

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 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. – 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. This is because resources available in the North West Ambulance Service cannot be fully utilised as a result of the delays in ambulances clearing Accident and Emergency departments.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 3rd July 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 a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. 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.
9	**Lauren Costello** **HM Assistant Coroner** L. Costello **08.05.2024**