REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) NHS England
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 25th October 2023 I commenced an investigation into the death of Bernard Compton. The investigation concluded on the 9th May 2024 and the conclusion was one of NARRATIVE: Died from a complication of a myocardial infarction when delays in identifying he had a myocardial infarction meant that the time for a successful percutaneous coronary intervention had passed. The medical cause of death was **1a) Left ventricular rupture with Hemopericardium; 1b) Acute myocardial infarction; 1c) Coronary artery disease II Tobacco smoking.**
4	CIRCUMSTANCES OF THE DEATH On 13th October 2023 at about 20:23 Bernard Compton rang North West Ambulance Service reporting pain under his left arm, shortness of breath, shaking and sweating. He was categorised as a category 3. He was then assessed further and a taxi was sent to take him to hospital. He arrived at Tameside General Hospital at 21:37. He was streamed for an ECG based on his symptoms which included chest pain since 3pm that day. The ECG took place at 22:15. The machine indicated on the print out that he was having a myocardial infarction. It was misinterpreted by a doctor. It was to be repeated within 30 minutes. That did not happen. He was triaged at 23:24. A triage should have taken place within fifteen minutes but did not due to significant

	demand on the department. He was categorised as urgent and should have seen a clinician within ten minutes. He was sent to sit in the main waiting area. At 02:06 the results of his bloods taken at 22:20 were reported on the hospital's electronic system. They showed a significantly raised troponin. He was still in the waiting area. He had not seen a member of staff or been checked on. His results on the system were not reviewed until 05:12 due to demands on the staff. He had not been reviewed since he was triaged. He had left the department due to the wait and not being seen. Greater Manchester Police and the North West Ambulance Service were alerted. Greater Manchester Police returned him to Tameside General Hospital as delays with North West Ambulance meant there was a 45 minute wait for all category 2 cases, even though it was known he was probably having a heart attack. He was transferred to Wythenshawe (a tertiary cardiac centre) at 07:47. By that time the optimum 12 hour window for a successful intervention by percutaneous coronary intervention had passed. He remained at Wythenshawe. On 19th October 2023 he had a left ventricular rupture, as a consequence of the previous myocardial infarction and the damage it had caused to his heart and died.
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. The inquest heard evidence that the delays in the Emergency were due to demand and were not unusual. It was recognised that the delays presented a risk and steps had been taken to try to mitigate them but there was no evidence that particularly during the night hours any one person had oversight of patients or that there was a system to ensure effective management of patients. The situation Mr Compton experienced was a direct consequence of the lack of

	oversight and system. 2. It was unclear what system was in place to effectively ensure urgent blood results were acted upon immediately. The inquest was told the lab would telephone through on some occasions. It was unclear what the protocol was and who had oversight of it. 3. The ECG told the clinician that there was a likely MI. It was entirely unclear why that was not acted on. The clinician did ask for a repeat within 30 minutes. That did not happen. There was no evidence of a system to ensure tests were repeated and directed and how that was monitored. 4. When Mr Compton made his first call to NWAS he was exhibiting symptoms consistent with an ongoing MI. However the questioning via the algorithm did not pick that up. NWAS were unable to clarify why that was the case. A call from someone actively having a MI was therefore categorised as a category 3 despite the time critical nature of the condition. 5. Demand on NWAS meant that even though they knew he had been diagnosed as being in the throes of a MI they could not get an ambulance to him in less than 45 minutes due to demand on their services. 6. The consequence of delay in assessing and treating Mr Compton was that an opportunity to treat him effectively was not available to clinicians.
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 31st 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 Tameside General Hospital and 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**  **05.06.2024**