	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) [redacted], Chief Executive, West Midlands Ambulance Service. (2) [redacted], Chair, NHS England.
1	**CORONER** I am James Bennett Area Coroner for Birmingham and Solihull.
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 24/04/23 I commenced an investigation into the death of Robert John Fray. The investigation concluded at the end of the inquest on 23/05/24.
4	**CIRCUMSTANCES OF THE DEATH** On 04/04/22 at a dialysis session Mr Fray was advised to attend hospital due to being symptomatic of sepsis. Arrival of an ambulance was delayed due to exceptional but not unprecedented demand. Sequence of 999 telephone calls: No.1 - was made by a clinician from the Dialysis Treatment Centre at 18:03hrs and triaged by the call assessor via the Healthcare Professional Pathway as a category 3 response. No.2 - was made by a clinician from the Dialysis Treatment Centre at 19:32hrs and upgraded by the call assessor to a category 2 response. No.3 - was made by a clinician from the Dialysis Treatment Center at 22:17hrs. It was explained the centre was closing and Mr Fray was going home. He had a NEWS 1. The call assessor maintained the category 2 response upon it being reported there was no change in Mr Fray's presentation. No.4 – was made by a neighbour at 23:05hrs with Mr Fray presenting with worsening symptoms. As the address was different, despite Mr Fray's name being the same, the call assessor did not pick up it was a duplicate and this was triaged as a new category 2 response. In response to 999 calls no.1-3 an ambulance was dispatched at 23:32hrs and arrived at the Dialysis Treatment Centre at 23:46hrs to find it closed. The ambulance crew telephoned Mr Fray who confirmed he was at home. The ambulance arrived at his home address at 00:00hrs. He had a NEWS 10. He was admitted to the emergency department at Queen Elizabeth Hospital Birmingham around 01:16hrs on 05/04. Contrary to expectations, the ambulance crew did not pre-alert the hospital to 'red flag sepsis' and did not handover Mr Fray's high NEWS or suspected sepsis verbally upon arrival. The navigation nurse streamed him to 'ambulatory majors'. The nurse in charge of 'ambulatory majors' recorded clinical observations on the hospital handover sheet that should have triggered a sepsis alert and prompt treatment, which at that stage would have prevented his death. Mr Fray was directed to the waiting area where he remained from 01:16hrs until he was found unconscious in a chair at 16:35hrs. For reasons that remain unknown he did not respond when verbally called for triage at 02:53hrs, and at 04:39hrs he was incorrectly recorded as having left without being treated. The emergency department was under exceptional but not unprecedented pressure during a period of COVID restrictions and there had been no nurse available to monitor the waiting area. Upon

	assessment he was critically unwell with sepsis, which was the primary cause of his collapse, and he had suffered a stroke. He was treated with fluids and antibiotics but was not a candidate for thrombolysis. He developed worsening multi-organ failure and died on 09/04/22 from: 1a Multi-organ failure. 1b Right MCA stroke and dialysis acquired acute sepsis. 1c II End stage renal disease secondary to uncontrolled hypertension on haemodialysis. The conclusion as to the death was: "*Natural causes contributed to by a delay in diagnosis and treatment of sepsis. His death was contributed to by neglect."*
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. A volume of 999 calls over a longitudinal period (vs a volume of calls in a short space of time) does not trigger or prompt NHS Pathways to require the call assessor to consider whether a more urgent response is needed. The simple fact of repeated 999 calls over a longitudinal period may be an indicator of a worsening situation. Currently, the call assessor repeats at each call the question 'has the presentation changed?' and is reliant on the judgment of the caller who may not have the complete picture (e.g. Mr Fray's neighbour), rather than also having regard to the number of calls. 2. Linked, the automated 'duplicate checker' is based on checking location within a 250-meter radius and not the patient's name. As Mr Fray had moved more than 250 meters between 999 call no.3 and 999 call no.4, the call at 23:05hrs was not identified as a fourth call. It follows the call assessor was not prompted to ask whether his presentation had worsened and the ambulance was sent to an out-of-date location. This would not have happened had the 'duplicate checker' included Mr Fray's name rather than simply looking for a location within 250-meters.
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. West Midlands Ambulance Service are responsible for implementing NHS Pathways locally. NHS England are responsible for NHS Pathways.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 August 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: 1. Mr Fray's family. 2. University Hospital Birmingham NHS Trust. 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	 6 June 2024 James Bennett Area Coroner, Birmingham and Solihull