Kally Cheema LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

Tel: [redacted] | **Email:** [redacted]

Case Ref: [redacted]

29 October 2024

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: (1) The Transformation Directorate, NHS England and (2) The Secretary of State for Health and Social Care

CORONER

1 I am Robert Cohen, HM Assistant Coroner for Cumbria

CORONER'S LEGAL POWERS

2 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 2nd February 2024 an investigation was commenced into the death of Lee ARMSTRONG. The investigation concluded at the end of the inquest on 29th October 2024. The conclusion of the inquest was the following narrative:

Lee Armstrong was 24 years old. He lived in [redacted], Penrith. Mr Armstrong suffered from Addison's disease. On 30th January 2024, became unwell. A call was made to the ambulance service at 10:32 in which Mr Armstrong was told to contact his GP. Mr Armstrong became increasingly unwell over the course of the day. A further call was made to the ambulance service at 16:48 and an ambulance attended. Mr Armstrong was deeply unconscious and critically unwell; he was in the midst of an Addisonian Crisis. At
3 18:20 Mr Armstrong entered cardiac arrest. Mr Armstrong was resuscitated but his brain had been severely injured by the lack of oxygen. Mr Armstrong died as a result at 11:26 on 2nd February 2024.

The medical cause of Mr Armstrong's death was:

1a Hypoxic-ischaemic encephalopathy

1b Cardiac Arrest

1c Addisonian Crisis, Colitis, Cholecystitis

II Type 1 Diabetes Mellitus

CIRCUMSTANCES OF THE DEATH

When Mr Armstrong became unwell, he and his partner used the online 111 system. It indicated that they should dial 999 and call an ambulance. Evidence from an NWAS representative indicated that: 1) information inputted to the online 111 system is not available to ambulance call handlers (in contrast to information provided to 111 over the phone), 2) NWAS use the NHS Pathways system to triage 999 calls, and 3) NWAS call handlers do not have access to details of callers medical records.

In the course of the first 999 call Mr Armstrong reported that he was confused. This is
4 known to be a symptom of being in Addisonian Crisis. Mr Armstrong was not asked whether or not he had any pre-existing medical condition. I was told that the expectation is that a patient would volunteer their past medical history.

Evidence from NWAS indicated that if the call handler had been aware that Mr Armstrong suffered from Addison's Disease then they would have organised a Category 2 response. Instead a Category 5 was organised with the suggestion that Mr Armstrong contact his GP.

Mr Armstrong became progressively more unwell over the course of the day. A Category 1 Ambulance was sent when a further call was made at 16:48.

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 evidence indicates that knowledge that Mr Armstrong suffered from Addison's Disease would have dramatically altered the response to the call. However, the NHS Pathways system does not ask callers to indicate whether they have any existing
5 conditions. Instead, the onus is placed on patients to identify potentially relevant conditions. However, Mr Armstrong had indicated that he was confused. I am concerned that expecting a patient to volunteer crucial information about their condition, especially where that condition may cause confusion, places similar patients at risk.

(2) The evidence indicates that information supplied to 111 online is not shared with NWAS. This may mean that a caller expects that their medical history and condition are known by ambulance call handlers when this is not the case. This risks such callers not volunteering details of the medical history.

(3) I note that NWAS call handlers are not provided with access to (even an abridged version) of a patient's medical records. I am concerned that this means that call handlers cannot see relevant details of medical history.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you (1) NHS England and (2) The Secretary of State have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 24th December 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - Mr Armstrong's family and - NWAS.

8 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 29 October 2024

Signature

Robert Cohen HM Assistant Coroner for Cumbria