REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: 1) [redacted], Secretary of State for Health and Social Care; 2) [redacted], Chief Executive, NHS England.

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
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 21st June 2024, Anna Morris KC, Assistant Coroner for Manchester South, opened an inquest into the death of Simon Boyd who died at his home on 1st June 2024 aged 52 years. The investigation concluded with an inquest which I heard on 4th October and 4th November 2024.

The inquest determined Mr Boyd died as a consequence of:

1) a) Myocardial Infarction;

1) b) Coronary Artery Disease

II) Hypertension

At the end of the inquest, I recorded the following Narrative Conclusion:

Mr Boyd died as a consequence of a Myocardial Infarction which was first diagnosed after his death despite him seeking help from urgent and emergency care services.

CIRCUMSTANCES OF THE DEATH

Mr Boyd had a relatively complex medical background including aortic root dilation, hypertension, chronic fatigue syndrome and sleep apnoea. On 31st May 2024, he telephoned NHS 111 and had a remote assessment with a Clinical Assessor where he reported dizziness, lethargy and sweating. He was given self-care advice and advised to consult with his own GP or call NHS 111 if symptoms persisted. Safety-netting took place with Mr Boyd being told of red-flag symptoms.

At around 05:23 on 1st June 2024, Mr Boyd rang 999 requesting an ambulance as a result of breathlessness. Whilst a Category 3 ambulance response was originally initiated, review by the NWAS C3 service led to an onward referral being made to the Greater Manchester Clinical Assessment Service.

The referral was accepted and Mr Boyd was spoken to by a doctor who took a similar history and referred him to the local Out of Hours Service, cancelling the ambulance response.

Once it was established Mr Boyd was unable to make his own way to the Out of Hours Centre, Mr Boyd was spoken to by a further doctor, who triaged him for a routine (same day) home visit.

The visiting doctor arrived at Mr Boyd's property at around 08:34 but was unable to gain entry. Once police arrived, entry was forced and Mr Boyd was found unresponsive. Attempts to revive him were unsuccessful.

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. –

To the Secretary of State for Health and Social Care

1. The court heard evidence to the effect that, notwithstanding the national target for Category 3 999 calls of 9 out of 10 responses within 120 minutes, the anticipated wait for a Category 3 ambulance on 1st June 2024 was around 3 hours and 15 minutes. This is a factor which contributed to decision-making in this case.

   I am concerned that national targets for ambulance response times continue not to be adhered to.

To the Chief Executive, NHS England

1. I am concerned that the current wording of some of the script used by Call Handlers under NHS Pathways creates an impression that an ambulance has been dispatched to a caller at a point when this is, in fact, not the case.

   Phrases such as '*An emergency ambulance has been arranged*', '*we will be with you as soon as possible, as soon as an ambulance is available'* and '*if you can ask for someone to meet and direct the vehicle and shut any dogs away if there are any*' potentially give a misleading impression as to ambulance dispatch having occurred, which could conceivably deter a caller from taking steps which might realistically result in them obtaining faster help.

2. A further matter of concern arises from the potential under the NHS Pathways paradigm for an ambulance response to be cancelled without this first being discussed with the person who has felt it necessary to dial 999 and request an ambulance in the first place.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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, namely by

1st January 2025. 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 the legal representatives of Mr Boyd's family.

I have also sent a copy to NWAS, Mastercall, Bardoc and NHS Greater Manchester Integrated Care Partnership 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.

Dated: **6th November 2024**

Signature: Chris Morris HM Area Coroner, Manchester South.