Lancashire & Blackburn with Darwen Coroners

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (pursuant to Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. NHS Pathways
1.	**Coroner** I am Kate Bisset, Area Coroner for Lancashire and Blackburn with Darwen.
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 the 3rd April 2024 the Coroner's Office was notified of the death of James Paul Michael Masheter and an investigation commenced into his death. An inquest was opened and adjourned on the 11th April 2024 and a final inquest took place on the 13th of February 2025 with conclusions delivered on the 25th February 2025. The conclusion of the inquest was that: "James Paul Michael MASHETER died on the 1st April 2024 at his home address by hanging. Mr MASHETER had struggled with his mental health and had previously engaged in self-injurious behaviours. On the 31st March 2024, Mr MASHETER made a number of cuts to himself with a knife and telephoned friends telling them he was dying and asking for help. Mr MASHETER's friends called for an ambulance and one friend attended his home address. Mr MASHETER was distressed and bleeding from superficial wounds. Due to demands of the service, there were significant delays in ambulance allocation but Mr MASHETER's friend was told that that delay was significantly less than was the case. Believing an ambulance to be arriving imminently, the friend left

	Mr MASHETER, who went on to secure a ligature which caused his death. Incorrect information about the waiting times for ambulance attendance was provided to Mr MASHETER's friend and this contributed to his death. It is not possible to determine Mr MASHETER's intentions at the time at which he secured the ligature given his behaviour was in the context of a significant mental health crisis".
4.	**Circumstances of the death** Mr James Masheter was a 42-year-old man with a history of self-injurious behaviour when in a mental health crisis. Prior to his death, a relationship had ended and he had financial concerns. On the 31st March 2024, Mr Masheter telephoned his friend and ask for help as he was "dying". His friend telephoned 999 and requested an ambulance. The request was triage as a category 3 incident. There were 3 further calls to the ambulance service on the evening of the 31st March 2024. All resulted under the triage systems as a category 3. There were also significant delays in resource availability on this night. In the final 999 call, Mr Masheter's friend was told there were delays of one and a half hours and his original call was one hour ten minutes ago. Believing the ambulance to be due imminently, the friend left. The ambulance did not arrive until 08:10am on the 1st April 2024 and the crew found Mr Masheter deceased by hanging.
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. The NHS Pathways system is used for triage. This asks standard questions to ascertain the seriousness of the situation including whether the patient is awake and breathing and so on. The triage pathway includes some options for mental health situations but these are limited. Evidence was heard in the inquest that the North West Ambulance Service (NWAS) had liaised with NHS Pathways with a view to exploring how mental health calls are triaged. NHS Pathways declined to make any changes to mental health triage but offered advice to NWAS in how to triage mental health situations. 2. The evidence heard at the inquest was that notwithstanding the seriousness of the situation in which Mr Masheter presented, his appropriate categorisation was category 3. This led to significant delays in an ambulance attending. It is not clear to me whether it is possible for

	serious mental health crisis situations which present a risk to life are capable of being properly risk assessed on the basis of the NHS Pathways mental health triage which exists at present.
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 the 30th May 2025. 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 Person: The Family of Mr James Masheter; NHS England North West Ambulance Service 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.	**03.04.2025**  **Kate Bisset**

	Area Coroner for Lancashire and Blackburn with Darwen