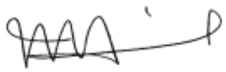
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NWAS (North West Ambulance Service)**
1	**CORONER** I am Jacqueline DEVONISH, Senior Coroner for the coroner area of Cheshire
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 03 January 2025 I commenced an investigation into the death of Edward Thomas WILSON aged 86. The investigation concluded at the end of the inquest on 04 June 2025. The conclusion of the inquest was that: Narrative Conclusion - Died following the administration of salbutamol nebulisers in the context of unrecognised significant heart failure
4	**CIRCUMSTANCES OF THE DEATH** Mr Wilson was attended at home by paramedics and on the second attendance transported to hospital by the ambulance service. The statements of the paramedics confirm that his observations were within normal ranges but that when auscultating his lung fields some fine crackles were heard from both lung bases without wheeze or stridor when attended at 11:43 hours on 28 December 2024. This was not on the face of it unreasonably diagnosed as a potential chest infection and was agreed by the GP AVS based at the hospital who dispensed antibiotics having taken into account the clinical history. When reattending at 19:35 hours Mr Wilson had a raised respiratory rate, a global wheeze on air, shortness of breath/difficulty breathing had worsened. The paramedics administered a salbutamol nebuliser as well as an ipratropium nebuliser which lasted the duration of the transit to hospital until cardiac arrest. The Consultant in Emergency Medicine stated that the withdrawal of blood pressure medication and administration of salbutamol nebulisers in the context of a known clinical history of significant heart failure contributed to the lowering of his blood pressure and repeated cardiac arrests on route to hospital.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) The attending paramedics did not take the significant history of heart failure into account when making the decision to administer the salbutamol nebulisers which had a direct impact on the outcome by the lowering of Mr Wilson's blood pressure.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 July 31, 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons **Legal Department, Macclesfield District General Hospital** I have also sent it to **Meadowside Medical Centre** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 05/06/2025**  **Jacqueline DEVONISH** **Senior Coroner for** **Cheshire**