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 Milton Keynes Urgent Care Service**
1	**CORONER** I am Tom OSBORNE, Senior Coroner for the coroner area of Milton Keynes
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 18 September 2024 I commenced an investigation into the death of Jordan Michael BABB aged 31. The investigation concluded at the end of the inquest on 25 June 2025. The conclusion of the inquest was that: **Narrative Conclusion** The deceased died of a pulmonary embolism which was not recognised or treated despite presenting with abnormal clinical observations suggestive of this condition. The decision to discharge the deceased without further investigation or escalation of care contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had been complaining of chest pain and had visited the Urgent Care Centre in Milton Keynes on Friday 13th September 2024. He was assessed and put on a nebuliser for his asthma. He was discharged with a follow up GP appointment. He was not investigated for a possible pulmonary embolism. On the 16th September 2024 he collapsed and despite resuscitation died of a pulmonary embolism at [redacted].
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) 1. Failure to Escalate Abnormal Observations Despite the patient presenting with a significantly elevated heart rate, high respiratory rate, and reduced oxygen saturations — all indicative of physiological instability — there was no escalation to secondary care or referral to the emergency department. There appears to have been no formal threshold or protocol in place to ensure that abnormal observations of this nature trigger an urgent clinical response. 2. Lack of Structured Risk Assessment for Pulmonary Embolism Although pulmonary embolism was a relevant clinical possibility, no structured risk

	assessment tool (such as the Wells score) was used or documented, and there was no attempt to apply an evidence-based diagnostic pathway as recommended by NICE guidance (NG158). 3. Unclear Use or Misunderstanding of Clinical Decision Tools Evidence suggested uncertainty about the appropriate use of the Pulmonary Embolism Rule-out Criteria (PERC) in primary care settings, with potential misapplication outside of the specific context recommended by NICE (i.e., in low-risk patients only and following validated pre-test probability assessment). There appears to be a lack of clarity or training regarding the scope and limitations of such tools in the primary care context. 4. Risk of Repetition in Similar Settings The inquest heard no evidence that the walk-in centre has a specific protocol or decision-support mechanism in place for the recognition and escalation of potentially life-threatening conditions such as pulmonary embolism. There is a risk that similar failings could occur in future, particularly where patients present with non-specific symptoms and abnormal vital signs.
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 19th September 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 **Family of Mr Jordan Michael BABB** 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: 25/07/2025**  **Tom OSBORNE**

	Senior Coroner for **Milton Keynes**