REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Emergency Call Prioritisation Advisory Group** **2. London Ambulance Service NHS Trust**
1	**CORONER** I am Sian Reeves, assistant coroner, for the coroner area of South London
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 15 February 2023, an inquest was opened, and an investigation commenced, into the death of Miles Brian Robinson, who was aged 66 at the time of his death. The investigation concluded at the end of the inquest, which was heard over 3 days between 4 and 6 June 2025. The medical cause of death was: 1a. Myocardial Infarction. 1b. Atherosclerosis. 2. End-stage renal failure. The conclusion was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** In the early hours of the morning on 19 December 2022, Miles Robinson started to have chest pains and was vomiting. He had multiple co-morbidities including end-stage renal failure, hypertension, heart failure and pleural effusion. His granddaughter called 999 at 03:37. Due to extreme demand on the London Ambulance Service ("LAS"), there was a significant delay in that call and a later 999 call being answered and there were significant delays in allocation and dispatch of ambulances. The 999 call was incorrectly triaged and received an inaccurate categorisation of the urgency of the response required. Having been informed that an emergency ambulance was not immediately required and of the wait times for an ambulance, Mr Robinson made his own way in an Uber to the nearest urgent treatment centre ("UTC") at Queen Mary's Hospital. Upon arrival, he had a cardiac arrest. This was due to a massive myocardial infarction. After prolonged CPR and shocks by staff at the UTC and attending LAS paramedics, a return of spontaneous circulation was achieved at 05:04. Mr Robinson was then transferred by ambulance to the local emergency department at Princess Royal University Hospital ("PRUH"). He had two further cardiac arrests shortly before and after his arrival at PRUH, which were fatal. He died at 06:36 on 19 December 2022.
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 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: In the UK, 999 calls are triaged using one of two approved triage tools (also referred to as call prioritisation systems) approved by NHS England: the Medical Priority Dispatch System ("MPDS") and NHS Pathways. LAS uses MPDS. The MPDS looks at signs and symptoms and prioritises them into dispatch codes, which assign a level of priority to the call, and in turn inform the type of ambulance resource that will be allocated to manage the incident. MPDS is designed for use by non-clinical call handlers. MPDS involves a system of structured questions which identify priority symptoms and thereby the clinical need of patients. The structured questions fall into different protocols and a patient can be shunted, or moved, between one protocol and another depending on the answers to specific questions. In these circumstances, and for sound operational reasons, there is necessarily an element of rigidity in the MPDS. In Mr Robinson's case, LAS accepted that the first 999 call was incorrectly triaged and received an inaccurate categorisation of the urgency of the response required: it was allocated a Category 3 (urgent) rather than Category 2 (emergency) response. Given the rigidity of the structured questions, there was no capacity within MPDS to account for information provided on behalf of Mr Robinson during the first 999 call, namely that he thought and felt like he was having a heart attack. The evidence heard at the inquest was that: (1) there are no individual MPDS determinants, under the relevant protocol, Protocol 10 (Chest Pain), that are specific for a heart attack; and (2) under the MPDS this information (reporting a heart attack) would not result in a dispatch code justifying a Category 1 (life threatening) response, with an average response time of 7 minutes and 90% of calls responded to within 15 minutes. This means that for a patient who is conscious and breathing, but reporting a heart attack, the highest possible category of emergency response on the MPDS Chest Protocol is Category 2 (average response 18 minutes; 90% calls within 40 minutes). However, this rigidity and categorisation may give rise to a risk of future death, namely: the risk their heart attack leads to a cardiac arrest immediately or shortly following the cessation of the call, and because they are on their own, they are unable to re-call 999; and/or the cardiac arrest may cause their death prior to a Category 2 (or subsequent Category 1) ambulance arriving at their location. This risk also arises in the context of increasing nationwide demand on UK ambulance services which has given rise to delays in allocation and dispatch of ambulances.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 2 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: • [redacted] (as the main representative of the family of Miles Robinson).

	• King's College Hospital NHS Foundation Trust. • The Hurley Group. • [redacted]. I have also sent it to NHS England, as the Emergency Call Prioritisation Advisory Group, is part of NHS England, 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 other 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.
9	**8 July 2025** **Sian Reeves**