REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Department of Health and Social Care
1	CORONER I am Alison Mutch senior coroner, for the coroner area of South Manchester
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 3rd February 2025 I commenced an investigation into the death of Ricky O'CONNELL .The investigation concluded on the 2nd July 2025 and the conclusion was one of narrative: Died from acute myocardial ischaemia in the context of a significant delay in an ambulance attending following a 999 call. The medical cause of death was **1a) Acute Myocardial Ischaemia 1b) Coronary Atherosclerosis**
4	CIRCUMSTANCES OF THE DEATH Ricky O'Connell's partner called for an ambulance at 05:44 when his overnight symptoms deteriorated and he was concerned he was having a heart attack. He was categorised as a category 2 call. On the Department of Health Standards that should result in an ambulance on average arriving within 18 minutes and in 9 out of 10 cases within 40 minutes. The ambulance had not arrived by 06:38 due to very significant delays across the North West, primarily due to prolonged hospital handovers and overall demand on the service. His partner called again. At 06:43 during that call he collapsed and the call was upgraded to Category 1. An Ambulance was dispatched (the earlier call was still in the queue for dispatch). CPR was given by his family and then the ambulance and he was transported to Tameside General Hospital where attempts to resuscitate him continued. He died at Tameside General Hospital on 27th January 2025.
5	<u>CORONER'S CONCERNS</u> 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 inquest heard evidence that it was accepted that adherence to the timescales should have resulted in an ambulance arriving before he collapsed. The evidence given was that NWAS had done a huge amount of work to try to improve ambulance response times. This included improved staffing and call handling. However delays in ambulances clearing ED was still having a very significant impact on their ability to respond to calls including category 2 calls such as the one for Mr O'Connell. 2. The inquest was told that the ambulance service was generally operating at full stretch due to the demand for their services. The reasons for the demand were multi factorial and included challenges in accessing primary care. 3. The inquest was told that generally the period towards the end of a nightshift could be the busiest and resulted in waiting times increasing further. On the day in question across GM some hospitals were taking up to 60 minutes extra over the accepted turnaround time to clear ambulances. This led to significant challenges for NWAS. 4. The inquest was told that in Greater Manchester all of the Trusts have improved their turnaround times overall in the last few months but due to very significant delays in ambulance turnaround times at other Trusts in particular in Cheshire and Merseyside, NWAS were still being adversely impacted in terms of available vehicles to respond to calls across the North West.
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 **15th October 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 namely the father of Mr O'Connell and North West Ambulance Service , 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.
9	**Alison Mutch** **HM Senior Coroner**  **20/08/2025**