

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b><u>The Crescent Surgery</u></b>  <b>Cleveleys Health Centre</b>  <b>Kelso Avenue,</b>  <b>Thornton Cleveleys,</b>  <b>Lancashire</b>  <b>FY5 3LF</b>    </p> <p><b><u>Broomwell HealthWatch Ltd</u></b>  <b>TeleMedical Monitoring Services</b>  <b>Barlow House (3<sup>rd</sup> Floor)</b>  <b>4 Minshull Street</b>  <b>Manchester M1 3DZ</b>    </p>
1	<p><b>CORONER</b></p> <p>I am Alan Anthony Wilson Senior Coroner for <b>Blackpool &amp; Fylde</b></p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.  <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a>  <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>The death of <b>Martin Ormond</b> on 25<sup>th</sup> January 2025 was reported to me and I opened an investigation, which concluded by way of an inquest on 13<sup>th</sup> February 2026.</p> <p>I determined the medical cause of death to be:</p> <p><b>1 a Acute myocardial infarction</b>  <b>1 b Coronary artery atheroma</b></p> <p><b>2 Bronchopneumonia, Essential hypertension, Type 2 Diabetes Mellitus</b></p>

	<p>In box 3 of the Record of Inquest I recorded as follows:</p> <p>Martin Ormond was aged 65 years. Concerned he may have a chest infection, he attended his GP surgery on the afternoon of 23<sup>rd</sup> January 2025. An ECG was performed but the risk he may suffer significant cardiac damage was not fully recognised and he was not advised to go to hospital. A cardiology referral was made which, it was envisaged, would lead to an outpatient appointment approximately two weeks later. After two days, on 25<sup>th</sup> January 2025, at 10.40 am, a request was made for an ambulance and it was reported that Martin had passed out but then during that call he appeared to recover, and by agreement the request for an ambulance was cancelled. That afternoon, further calls were made to the ambulance service during which concerns were raised about Martin’s fluctuating level of consciousness. At 1.26 pm an ambulance crew attended his home. An ECG was suggestive of a potential heart attack, but the urgency of the response indicated by that ECG was under-appreciated by the ambulance service personnel. Given the available evidence, a confusing situation ensued which culminated in the ambulance crew leaving the property on the understanding Martin and his Wife preferred to make their own way to hospital by way of their own transport, whilst Mrs Ormond felt she and Martin, buy not travelling to hospital in the ambulance, were acting on advice from the paramedics. Shortly after the paramedics left his home, and in the absence of cardiac monitoring, Martin’s condition deteriorated and a further call was made which led to a second ambulance crew attending. They arrived at his home some 27 minutes after the first crew had departed. They found Martin unresponsive and transferred him to hospital. Despite sustained CPR efforts from his family, paramedics and hospital personnel, he could not be revived and Martin died in the Emergency Department at 4.05 pm. A subsequent post mortem examination confirmed he died from the effects of an acute myocardial infarction. His death was more than minimally contributed to be pneumonia.</p> <p>In box 4 of the Record of Inquest I determined the conclusion to be one of:</p> <p><b>Natural causes</b></p>
4	<p><b><u>CIRCUMSTANCES OF THE DEATH</u></b></p> <p>In addition to the contents of section 3 above, the following is of note:</p> <ul style="list-style-type: none"> <li>• Two days before he died in hospital, Martin Ormond underwent an ECG (Electrocardiogram) at The Crescent Surgery on 23<sup>rd</sup> January 2025.</li> <li>• At the inquest, evidence about this was provided by a Nurse Practitioner and a GP.</li> <li>• The court heard that the Nurse Practitioner forwarded the ECG to an external company - Broomwell HealthWatch Ltd –_who were to interpret the ECG. The ECG trace was considered, and a report sent to the Nurse Practitioner.</li> </ul>

	<ul style="list-style-type: none"> <li>• Some nine minutes later, a further report was sent to the Nurse Practitioner which included some additional comments as follows: <i>“Following further thought I would suggest this man is referred to A&amp;E and hopefully angiography can be performed. ST elevation in a aVR and reciprocal ST depression elsewhere is suggestive of triple vessel disease and there is the risk that if the fast AF persists there may be a worsening of any O2/ perfusion mismatch resulting in worsening subendocardial ischaemia”.</i></li> <li>• The evidence of the GP was that he had seen the ECG trace, but could not recall seeing either of the two subsequent reports provided by Broomwell HealthWatch. Neither did he recall being told verbally by the Nurse Practitioner that reference had been made to “triple vessel disease”, stating that had this been mentioned to him, he would have spoken to Mr Ormond and his Wife “to advise them he needed to be reviewed in hospital for further investigations, and that he needed to go to hospital within 24 hours”.</li> <li>• The GP (who further to Mr Ormond’s death has now left the GP practice] and the Nurse Practitioner provided helpful evidence at the inquest, but it was lacking in clarity in some aspects, and I determined that the GP made decisions regarding Mr Ormond’s care at a time when he did not have the information he needed.</li> <li>• It transpired that Mr Ormond was not advised to go to hospital at that time, but that a cardiology referral was made which meant he would most likely not be seen by a relevant medical professional for a period of around two weeks. It follows he had not seen a cardiologist by the time he died on 25<sup>th</sup> January 2025.</li> <li>• The Nurse Practitioner informed the court that although Broomwell Healthwatch interpret many ECG traces for the GP surgery, he could not recall a previous occasion when a second report has been sent to the surgery in order to highlight some “additional comments”. When the second report was sent by email to the GP surgery, notwithstanding it was sent quickly, it seemed to me feasible that medical professionals may make decisions based on the first report, and that any important additional comments may go unnoticed, thereby placing patients at risk.</li> </ul> <p>Having considered all of the above, I have determined that I have a duty to write this report.</p>
5	<p><b><u>CORONER’S CONCERNS</u></b></p> <p>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 send the report:</p> <p>The <b>MATTERS OF CONCERN</b> is as follows. –</p> <ol style="list-style-type: none"> <li>1. At the GP surgery, a GP made decisions in the absence of the necessary information – notably two reports submitted by an external company asked to</li> </ol>

	<p>interpret an ECG trace - and it did not seem that there was an effective process in place to ensure GPs are provided with the necessary information.</p> <p>2. In the event the external company decides to submit an amended report, there appeared to be no effective process in place to ensure what may be important additional information reaches the relevant GP before important decisions are made regarding patients.</p> <p>I believe it is necessary for to raise this concern, but it is not for me to be prescriptive about what should / can be done.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, but I have extended this period to 30<sup>th</sup> April 2026. I, the coroner, may extend the period further.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ul style="list-style-type: none"> <li>• The family of Martin Ormond</li> <li>• North West Ambulance Service</li> <li>• [REDACTED], GP.</li> </ul> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	18/02/26