Care Quality Commission
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NE1 4PA
[redacted]

Ms Linda Lee
Acting Coroner
Coroners Area of Coventry
Manor House Drive
Coventry
CV1 2ND

13 May 2026

Dear HM Acting Coroner, Linda Lee,

Regulation 28 Report following the death of Mr Roman Louis BARR

Thank you for bringing the Regulation 28 Report to our attention following the inquest into the death of Mr Roman Louis BARR who died on 14 December 2023 after suffering an asthma attack. Mr Barr died at University Hospital Coventry after being brought to the hospital by his parents. We acknowledge the concerns you have raised and appreciate the opportunity to respond.

We would like to express our sincere condolences to Mr Barr's family and loved ones following his death in such tragic circumstances.

We note your Regulation 28 report was addressed to multiple organisations. This response is prepared solely on behalf of the Care Quality Commission (CQC) as far as I am able and relates to the role of CQC and our regulatory work with those organisations we regulate.

We have noted the matters of concerns listed below in respect of those organisations involved in his care:

1. **Limited awareness of salbutamol overuse**

   Evidence showed that patients and families may not appreciate the clinical significance of increased use of the blue (salbutamol) inhaler or its association with poorly controlled asthma.

2. **Identification and follow-up of reliever overuse**

   Evidence showed that excessive or repeated requests for salbutamol inhalers may not be reliably identified within existing systems, and there may be no consistent process for follow-up when such patterns occur, meaning deteriorating asthma may go unrecognised.

We have given consideration to points 1 and 2 above. We note from evidence provided to the Coroner by Mr Barr's GP that actions have been taken at that practice to consider how to more effectively monitor potential overuse of inhalers and ensure patients and families are aware of the risks therein.

We note issues with overuse of asthma relieving medicine is in line with the Medicines and Healthcare products Regulatory Agency (MHRA) Drug Safety Update (DSU): Short-acting beta 2 agonists (SABA) (salbutamol and terbutaline): reminder of the risks from overuse in asthma and to be aware of changes in the SABA prescribing guidelines, 24 April 2025. We have written internally to our Chief Inspector of Primary Care and Community Services, [redacted], CBE, to ask her to remind colleagues and the wider community in primary care to ensure assessment of general practices includes reference to the MHRA DSU when conducting our regulatory work.

3. **Ambulance handover delays affecting emergency availability**

   Prolonged ambulance handover times at local hospitals were a significant factor in no ambulance being available at the time help was sought, reducing emergency response capacity during periods of high demand.

We have given consideration to point 3 above. In inspections of NHS Ambulance Services across England in recent years, we have had cause to take enforcement action where ambulance services are unable to meet response times for those patients who are critically unwell – typically those, as with Mr Barr, who would meet the category 1 or 2 threshold for requiring an emergency ambulance in a mean average time of 7 or 18 minutes or less respectively.

This includes taking regulatory action taken against West Midlands Ambulance Service (WMAS) in 2023 (as referred to in the coroner's bundle p53 and p54 points 7.4.4 and 7.4.5), although with recognition of how the delays in handing over patients at NHS emergency departments was the critical factor in not releasing ambulances back into the community. Since that action was taken, there has been a steady and welcomed improvement in the response times of WMAS. When we inspected and published our inspection report, the response time for category 2 incidents at WMAS (which are the largest category of ambulance incidents) was 48 minutes and 12 seconds. The 90th centile 40-minute response time was 110 minutes and 46 seconds. In the latest NHS Statistical Data report (March 2026) WMAS attended category 2 patients in 19 minutes and 30 seconds (mean average) and 38 minutes and 34 seconds (90th centile).

We have also taken regulatory actions against NHS trusts where the emergency departments are not taking handover from ambulance crews in safe and responsive times. Equally this was with recognition of how delays in getting people discharged home who were waiting in the same trusts' hospital wards without criteria to reside was the critical factor in not having beds to admit patients who required them in an

unplanned emergency. We have also written extensively on this point in the CQC State of Care reports in recent years.

4. **Risks when families transport critically unwell patients**

   The absence of an available ambulance for several hours resulted in the family transporting Roman to hospital themselves, exposing both him and his family to significant risk during a time-critical medical emergency.

5. **Clarity of NHS Pathways triage wording**

   Evidence showed that a key NHS Pathways question used during triage was not understood by the caller and did not elicit clinically significant information. This raises a concern that, given the reliance on scripted triage systems, such scripts may not always use wording that is easily understood by lay callers in distress.

We have given consideration to points 4 and 5 above. We have had further conversations with WMAS about the guidance and advice given to patients by its NHS Pathways system or the script used in times of crisis when vehicles to attend are not available. We asked whether there was guidance given to families and friends who have either been advised or have opted to take the patient directly to hospital.

The director for the emergency operations centres advised that following previous cases heard by the coroner, WMAS has changed the script used since the case in question here and now says and asks:

"The Ambulance Service Is Under Significant Pressure, And We Don't Have An Ambulance Available To Respond To (You /The Patient). It May Be A Number of Hours Before One Is Available. Is There Any Way You Can Arrange To Safely (Make Your Own Way / Take The Patient) To A Hospital Emergency Department?"

If the answer is "yes" then the caller is provided with instructions as to what to do if the patient deteriorates and asked to ensure they have a mobile phone with them.

Also, following a review by NHS Pathways of the triage system for severe asthmatics, the process has changed. WMAS state that should the case of Mr Barr present today in exactly the same way the case would be prioritised as a category 1. Mr Barr's case was classified at the time as a category 2. In order to trigger a category 1 response, the system required 2 positive answers, one of which was "*is the patient a deathly colour?"* This question would have required a positive answer (coupled with a positive answer to one of the other key questions) but now only 1 positive answer is needed.

Furthermore, your Prevention of Future Death report does state how: "*A recommendation made during the subsequent review to amend this NHS Pathways wording was not accepted by those responsible for the system's content."* (p2 section 4 CIRCUMSTANCES OF THE DEATH). I have been informed by WMAS that: "*The West Midlands Ambulance Service have requested that a category 1 emergency ambulance can be received for acute asthma with fighting for breath and*

confusion/agitation/drowsiness alone. This would mean removal of the second discriminator of "deathly colour" to identify clinical shock. Removal of this triage question would increase the number of those reaching a category 1 emergency ambulance and represent an uplift from the category 2 emergency ambulance. This would then align the pathway with that of the British Thoracic Society's definition of life-threatening asthma. NHS Pathways subsequently accepted our recommendation and removed the need for "deathly colour" to be identified to reach a category 1 for life threatening asthma."

I trust that the considered response provided, alongside the actions undertaken by the Care Quality Commission, offers the necessary assurance in accordance with our regulatory responsibilities. We will continue to monitor registered healthcare providers against compliance with regulatory standards to ensure that learning from this case is embedded into practice. We remain committed to supporting improvements in patient safety and care quality across all services.

Yours sincerely

Deputy Director of Secondary and Specialist Care
Central Region