Mr Sean McGovern
H M SENIOR CORONER

Mr Delroy Henry
H M AREA CORONER

Coroner's Office

[redacted]

Date: 4 March 2026 [redacted]

In the county of West Midland

Coroners Area of Coventry

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

1 **THIS REPORT IS BEING SENT TO:**

- Secretary of State for Health and Social Care
- NHS England
- NHS Pathways/NHS Digital (NHS England Transformation
- Royal College of GP's
- Asthma & Lung (for information)
- Care Quality Commission

2 **CORONER**

I am Linda Lee, Acting Area Coroner for the Coroner area of Coventry

3 **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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
INVESTIGATION and INQUEST
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

A coronial investigation into the death of Roman Louie BARR, aged 22 who died on 14 December 2023, was opened on 20th June 2024 and concluded on 3 March 2026.

The inquest was conducted without a jury. The conclusion reached was a short factual narrative:

"The deceased died as a result of an asthma attack. Information indicating the need for an urgent ambulance response was not obtained, and because no ambulance was available for

several hours, he was taken to hospital by his family. On the balance of probabilities, earlier intervention by an emergency ambulance would have prevented his death."

Medical cause of death:

1a) Asthma

4 **CIRCUMSTANCES OF THE DEATH**

On 14 December 2023, Roman Louie Barr suffered an asthma attack. His father collected him from work and took him home, where Roman used his nebuliser without improvement. Three calls were made to the ambulance service. During these calls, Roman was assessed as Category 2, and the family were twice advised that no ambulance would be available for several hours. They were asked whether they could transport him to hospital themselves and took the decision to do so.

Evidence established that at the time of the first call, Roman was critically unwell, displaying symptoms including bluish lips, but this information was not elicited during triage. Roman was of mixed ethnicity and had a darker skin tone, as his father explained to the call handler. The NHS Pathways question requiring confirmation that the patient was "*a deathly colour*" was not understood by his father. Clearer prompts—such as asking whether the lips were blue or grey—were not asked. A recommendation made during the subsequent review to amend this NHS Pathways wording was not accepted by those responsible for the system's content.

Ambulance availability was severely constrained due to significant delays in hospital handovers, leaving no crews free to respond. On the balance of probabilities, had clearer wording been used and the relevant information obtained, Roman would have been categorised as Category 1, for which an ambulance would be expected to arrive within approximately ten minutes even during surge conditions.

While being driven to hospital, Roman suffered a cardiac arrest. His mother moved into the footwell of the passenger side and commenced CPR as they continued their journey. On arrival at the hospital, the family vehicle was involved in a collision, during which Roman's mother sustained serious injuries. Roman could not be resuscitated and died shortly after arrival.

I also heard evidence that Roman had been using his blue (salbutamol) inhaler more frequently than recommended, indicating poor asthma control, and that neither he nor his family were aware of the clinical significance of this increased use. Following his death, the GP practice conducted a review and introduced measures to better identify and monitor patients with high salbutamol use, including keeping a list of such patients, automatically booking reviews when further inhalers are requested, liaising with community pharmacists, and placing alerts on patient records to support timely assessment.

Notwithstanding the Drug Safety Update issued on 25 April 2025 reminding clinicians of the risks associated with increased salbutamol use, the evidence in this case indicates that the importance of excessive reliever use may still not be fully recognised by patients or by primary care.

5 **CORONER'S CONCERNS**

I have identified the following matters of concern, giving rise to a risk of future deaths:

The **MATTERS OF CONCERN** are as follows. –

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.
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.
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.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to act.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th April 2026.

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**

A copy of this report has been sent to the Chief Coroner and Interested Persons. It may be published on the Judiciary website.

The following interested persons:

The family of the deceased

The ambulance service responsible for the 999 response

The acute hospital trust involved in the deceased's care

The primary care provider involved in the deceased's care

9 Signature 

Acting Area Coroner for Coventry Coroners

4 March 2026