REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. North West Ambulance Service**
1	**CORONER** I am Benjamin Myers KC, Assistant Coroner for the coroner area of Greater Manchester South
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 the 22nd January 2024, an inquest was opened concerning the death of Yunus Hoque, aged 13 years at the time of death. The inquest was heard with a jury on the 9th February 2026 to the 12th of February 2026. The jury found the medical cause of death to be: **1a) Multi-organ failure** **1b) Group A Streptococcus bronchopneumonia and Sepsis** The jury returned a conclusion of **natural causes contributed to by neglect.**
4	**CIRCUMSTANCES OF THE DEATH** On the 14th January 2024, Yunus Hoque became ill with a viral infection. Over the course of the following week he became increasingly unwell. A Group A streptococcal infection overlayed the viral infection. By the 18th January 2024, Yunus was struggling to lift his head from his pillow, he had a high temperature and he could not walk downstairs unaided. He was sleepy and ceased to eat. He continued to deteriorate. His mother called 111 at 22:42 hours on the 21st January 2024. The outcome of the assessment by North West Ambulance Service ['NWAS'] in that call was that this was a Category 2 response. Category 2 had an average response time of 18 minutes. His mother was informed that there would be an ambulance in about an hour. By 00:52 no ambulance had attended, by which time Yunus was having a seizure. His mother called 999 and on assessment during that call, this was now a Category 1 response. The average response time for Category 1 was 7 minutes. An ambulance was allocated at 00:56 hours and arrived at Yunus's home at 01:01 hours. Yunus arrived at Tameside General Hospital at 01:20 hours, by which time he was in respiratory arrest. He went into cardiac arrest at the hospital. There was no response to repeated attempts at resuscitation. Death was certified at 02:53 hours.
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. –

	1. The target response time for a Category 2 response was 18 minutes. The caller was told that an ambulance would be with Yunus in about an hour. 2. A period of approximately 2 hours elapsed during which no ambulance arrived, and before the caller, Yunus's mother, called 999. During this period, no communication was received by the caller from NWAS, or on their behalf, to inform her that there would be this unforeseen delay. 3. During this 2 hour period, Yunus's condition deteriorated further, moving from Category 2 to Category 1. 4. No further calls had been made by Yunus's mother during this period because it was her understanding that an ambulance would be with Yunus within the period of time indicated in the first call. Therefore she waited. 5. The evidence at the inquest established that the categorization in each call was at the appropriate level. 6. However, it is apparent that in circumstances where there is a significant delay over and above that indicated to the caller, there is no follow-up call or communication to indicate further delay, to confirm the status of the patient, or to suggest that alternative transport is required, if possible. Notwithstanding this, in a changing situation, a patient may deteriorate, moving from Category 2 to Category 1 and therefore requiring a more urgent response: as was apparent from the evidence at this inquest. But a patient, family member and / or carer who relies upon information already provided by the call handler, may continue to wait for an ambulance that they have been told will arrive in a given period of time, when in reality there is no likelihood of that ambulance arriving. At the same time, NWAS will be proceeding on the basis that they are dealing with a Category 2 when the case has now become a Category 1. 7. The evidence established that Yunus was so ill by the time of the first call to 111 at 22:42 on 21st January 2024, that the delay in the arrival of an ambulance did not contribute to his death. 8. Nevertheless, the absence of any system for a follow-up call by or on behalf of NWAS in circumstances where an unforeseen delay in ambulance attendance is going to be far in excess of that indicated to the caller, creates a risk that further deaths could occur, given that during this period a patient may deteriorate and their categorization can move to Category 1 from a lower category.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [and/or your organization] 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 **23rd April 2026**. 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:

	Mother of Yunus Hoque, on behalf of the family, Tameside Metropolitan Borough Council, Tameside General Hospital 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. She may send a copy of this report to any person who she 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	**Date: 26th February 2026** [redacted] **Benjamin Myers KC** **HM Assistant Coroner** **Greater Manchester South**