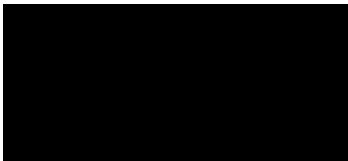


**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Crispin OLIVER, Senior Assistant Coroner, for the coroner area of County Durham and Darlington.
2.	DATE OF REPORT 24 July 2026
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.
4.	THIS REPORT IS BEING SENT TO 1. National Medical Director NHS ENGLAND You are under a duty to respond to this report within 56 days of the date of this report, namely by September 18, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary .
6.	SUMMARY OF CORONER'S CONCERN Discrepancies in how cases are categorised by the pathway algorithm.

7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 18 October 2019 I commenced an investigation into the death of Andrew Edward WATSON aged 32. The investigation concluded at the end of the inquest on 24 July 2026. The conclusion of the inquest was that: He died natural death to which the delayed arrival of an ambulance contributed.
9.	CIRCUMSTANCES OF DEATH Andrew was pronounced dead at 19.45 on 10 October 2019 at Cecil Court, Langley Moor, from a critical medical condition requiring emergency treatment for survival. This was not delivered in time because of delays in the response of the ambulance service.
10.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: Andrew died on 10 October 2019 as a result of 1a) Respiratory Failure due to Upper Airway Obstruction due to 1b) Peri-Tonsillar Abscess. He called 999 himself. Delays in the arrival of the ambulance contributed to the death. The evidence from the ambulance service, North East Ambulance Service, was that he had been correctly triaged under the pathway algorithm to a Category 2 response. I am concerned that, according to the evidence I heard in relation to the pathway algorithm, choking due to intrusion of a foreign object generates a category 1 response whereas choking due to a preventable but equally life-threatening natural cause generates only a category 2. The evidence from NEAS was that because Andrew was making the call himself and that it was not made by a third party was material to categorization, therefore I am also concerned that simply because he self-helped that this somehow reflected in a lower categorization. Finally, I am also concerned that a clearly life threatening condition, albeit preventable with critical care intervention, which in the event proved fatal in this case, is treated as a warranting a category 2 response rather than category 1.
11.	COPIES AND PUBLICATION OF THIS REPORT

	I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: <i>[please do not use individual's names, but instead roles/titles]</i> • Andrew's family • NEAS - I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE  Crispin OLIVER Senior Assistant Coroner for County Durham and Darlington