ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Department of Health** 2. **North West Ambulance Service** 3. **Manchester Medical Services** 4. **Salford Royal Hospital NHS Trust**
1	**CORONER** I am Joanne Kearsley, Area Coroner, for the coroner area of 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 14/12/12 I commenced an investigation into the death of Martin Daffydd Barker. The investigation concluded at the end of the inquest on 05/09/13. The conclusion of the inquest was that the deceased died as a result of MDMA toxicity and I recorded a verdict of Misadventure.
4	**CIRCUMSTANCES OF THE DEATH** On the 9th December 2012 the deceased was on a night out with friends. They attended the Warehouse Project in Trafford which is a venue which runs events on weekends between September and January. There are approximately 5000 people who attend the venue at these times. During the course of the evening the deceased took a quantity of the drug ecstasy (MDMA). He became unwell and was taken to the medical services on site at the venue. This Service is run by Manchester Medical Services. He was assessed as requiring emergency admission to hospital and was taken by Manchester Medical Services in their ambulance to Salford Royal Hospital. Despite attempts at resuscitation he was pronounced deceased at Salford Royal. His cause of death was confirmed as 1a) MDMA toxicity. Following Mr Barker's death concerns were raised by the Resus Unit at Salford Royal Hospital. On arrival at the hospital Mr Barker was in cardiac arrest, however the Resus team had not received a prior warning that the ambulance was en route to the hospital and therefore were not expecting them and were not prepared and on standby. There is a telephone number within the hospital Resus Department, which is allocated to the regional ambulance service, in this case North West Ambulance Service, who if they are en route with a patient can call to notify the hospital so that they can be ready anticipating their arrival and the patient is categorised as either a 'Red' or 'Amber' category according to their seriousness. In addition in this case, at 3am (which was the time Mr Barker arrived at the hospital) the Resus Reception Desk is not always staffed as the receptionist has other responsibilities which take her away from the desk. The entrance to Resus is through a door from the ambulance bay which has a locked keypad. At the point Mr Barker arrived in cardiac arrest, the receptionist was not at her desk and Manchester Medical Services did not

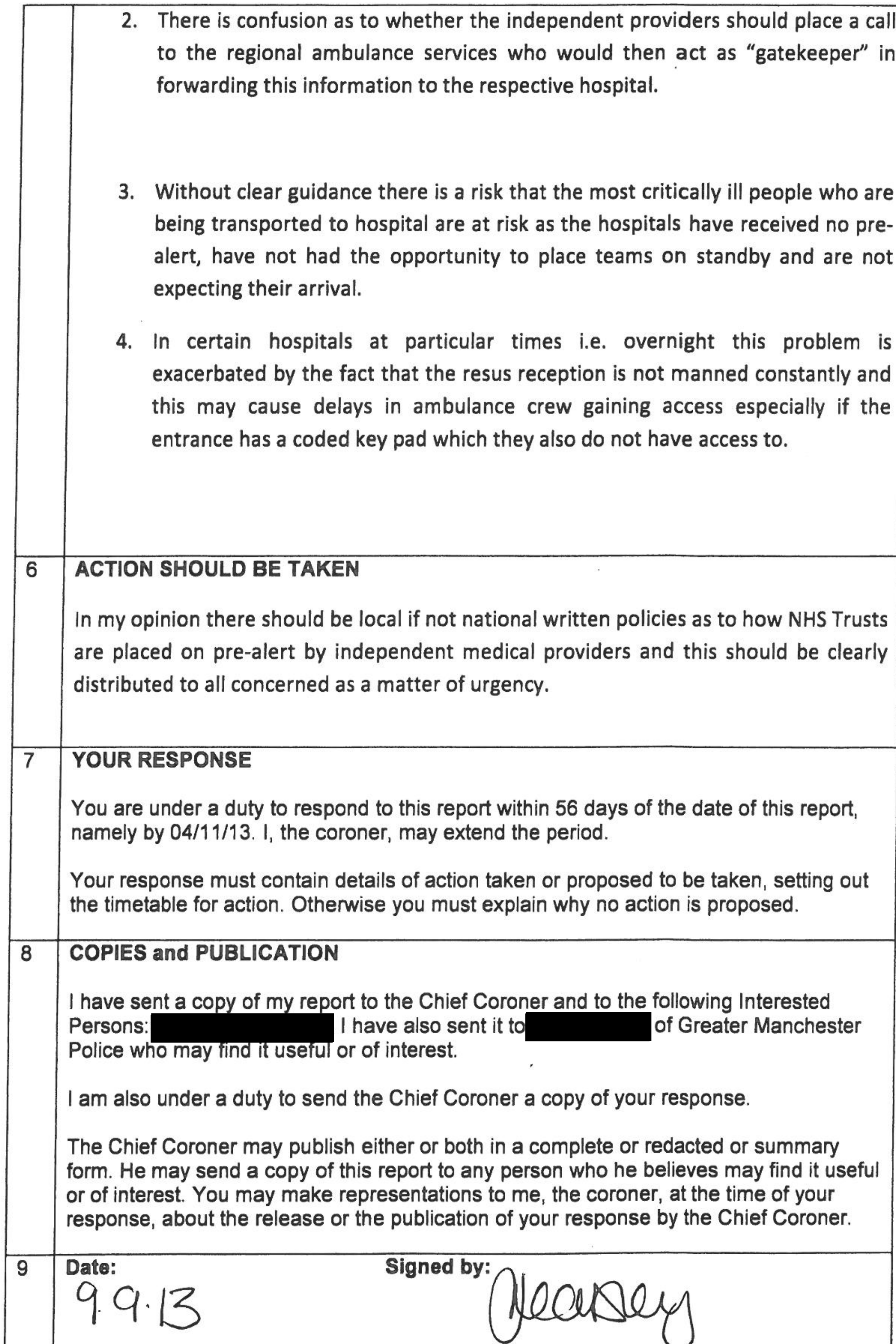
have the keypad code in order to access the door. On this occasion security staff happened to be passing and were able to assist in gaining entry.
Manchester Medical Services are one of a growing number of independent medical providers. They are contracted to provide medical cover at large events, approximately 900 per year throughout the UK. Many of the events involve in excess of 10,000 people. They have as part of their medical cover ambulances to transport people to hospital should this be required. At the Inquest I heard evidence from Salford Royal Hospital, Manchester Medical Services and North West Ambulance Service.
All confirmed in evidence to me that this was potentially a national problem and that there was no clear guidance or policy in place nationally or locally.
Salford Royal indicated that it was their understanding from event planning meetings which had taken place in 2011 around the Manchester Pride event that the position was that independent providers such as Manchester Medical Services should, if they are on the way to hospital with a critical patient, ring North West Ambulance Services who would then telephone the relevant hospital and notify them of the impending arrival.
It was clear that up to present there has been a refusal to provide independent providers with the telephone number so that they can use this directly. It was somewhat unclear whether this refusal to disclose the number was by the NHS Trusts or North West Ambulance Service. There were understandable concerns that the number should be used appropriately and that there should be a uniform approach to classifying patients as 'Red' or ' Amber' (this simply being a North West Ambulance Service classification.)
The Director of Manchester Medical Services gave evidence and indicated that this issue is raised by them at every planning meeting they attend for major events. However they are consistently refused the pre alert telephone number. It was also the understanding of Manchester Medical Services that despite previous discussions North West Ambulance Service will not act as an intermediary to place the pre-alert call through to the relevant NHS Trust as the independent ambulances are not on the NWAS system. He indicated in evidence that the only time NWAS will place a pre-alert call is if they have their own crews at an event together with the independent providers and a member of NWAS places the call into their operators.
Since this incident Manchester Medical Services have made further attempts to obtain the pre alert telephone number to no avail. He also confirmed that an ideal situation would be not to involve NWAS but for them to be able to use the number directly.
Angela Lee, Sector Manager for NWAS, then gave evidence and she indicated that it was her understanding that NWAS would act as an intermediary for the independent medical providers to place calls through to NHS Trusts to alert them and that NWAS would not want the telephone number directly provided to other medical service providers, although she could not explain the rationale for this. She also indicated that she would expect NWAS to then triage the patients over the telephone in accordance with NWAS policies and to categorise them in line with NWAS categorisations. This was somewhat surprising given that NWAS will not have any contact with the patient and are in no way involved in their transportation to hospital.
What was agreed by all who gave evidence was that there are no written policies locally or nationally and that all would be greatly assisted by the same.

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 will 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. There appears to be no national guidance on how independent national providers of medical services (particularly those covering large scale public events) can put NHS hospitals on standby for incoming urgent patients, something which is normal procedure for the regional ambulance services.



	2. There is confusion as to whether the independent providers should place a call to the regional ambulance services who would then act as "gatekeeper" in forwarding this information to the respective hospital. 3. Without clear guidance there is a risk that the most critically ill people who are being transported to hospital are at risk as the hospitals have received no pre-alert, have not had the opportunity to place teams on standby and are not expecting their arrival. 4. In certain hospitals at particular times i.e. overnight this problem is exacerbated by the fact that the resus reception is not manned constantly and this may cause delays in ambulance crew gaining access especially if the entrance has a coded key pad which they also do not have access to.
6	**ACTION SHOULD BE TAKEN** In my opinion there should be local if not national written policies as to how NHS Trusts are placed on pre-alert by independent medical providers and this should be clearly distributed to all concerned as a matter of urgency.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 04/11/13. 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: I have also sent it to of Greater Manchester Police who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. 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.
9	**Date:** 9.9.13 **Signed by:**