REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Clinical Director, NHS Pathways via email to:** [redacted]
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
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** Caragh Melling died on 27 December 2014, aged 37 years, from an unascertained cause. An inquest into her death was heard on 27 April 2016, at which I recorded a conclusion of natural causes. I was satisfied that, although the medical cause of death could not be determined on the balance of probabilities, her death was not unnatural.
4	**CIRCUMSTANCES OF THE DEATH** Ms Melling collapsed at home on 27 December 2014, after an episode of dizzyness. Emergency services were called by Ms Melling's partner, however the triaging failed to recognise that she was suffering from agonal breathing. As a consequence no advice was given to her partner to commence resuscitation. On arrival of the ambulance crew Ms Melling was found to be in cardiac arrest. Resuscitation attempts were unsuccessful and Ms Melling died shortly after arrival at hospital.
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) I heard evidence from the Ambulance Trust that a previous triage system included a tool which could recognise the presence of agonal or inadequate breathing. The call handler would record every point at which the patient was noted to inspire. The tool would then alert the call handler to the presence of inadequate breathing. The Ambulance Trust noted that their current triage system, NHS Pathways, does not include this tool. They have instituted a local 'workaround'; a question that asks whether

	the patient's breathing is 'noisy'. If this is answered affirmatively, agonal breathing is presumed and the call categorised as the fastest response time being required (R1). I heard evidence that NHS Pathways were contacted in 2014 to raise the absence of the breathing analysis tool as being a cause for concern. No action appears to have been taken. I also understand that the Medical Director of the Ambulance Trust has again raised concerns at the national level but it is unclear whether any action is being taken.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee, has 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 22 June 2016. 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, Ms Melling's family and West Midlands Ambulance Service NHS Trust. 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	**27 April 2016** **Assistant Coroner R Brittain**