REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Officer** **NHS Digital** **1 Trevelyan Square** **Boar Lane** **Leeds** **LS1 6AE**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
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 6th day of June 2016 I commenced an investigation into the death of Harry Stuart Gill aged 72 years. The investigation concluded at the end of the Inquest which was concluded on the 24th day of August 2016. The conclusion of the Inquest was that Harry Gill died from a heart attack brought on by the effects of vomiting caused by an intermittent blockage in his bowel. His death could probably have been prevented but for the failure to appropriately assess his medical condition.
4	**CIRCUMSTANCES OF THE DEATH** Harry Gill became unwell and started to vomit on Saturday 28th May 2016. He was unable to tolerate food and was trying to take regular sips of water. At 09:56hrs on Wednesday 1st June 2016 Mrs Gill on behalf of her husband contacted NHS 111. The health advisor triaged the call using the vomiting pathway which should have led to a Green 2 response but was incorrectly processed. Arrangements were however made for a clinician to call back some two hours later. The clinician should have reached a Green 2 response but the triage was incorrectly processed. That call was concluded with advice that should the symptoms get worse or the condition change to ring back NHS 111. At 18:28hrs on Thursday 2nd June 2016 a further call was made to NHS 111 at which time the health assistant incorrectly processed the call and although a Green 2 response should have been reached instead arrangements were made for a clinical advisor to call back. Three and a half hours later at 21:55hrs. That call was correctly processed and that call concluded with the

	clinician indicating that an ambulance was going to be arranged. At 22:21hrs on the 2nd June 2016 a nurse from the Urgent Care Desk then telephoned Mr Gill indicating that the ambulance was not now be being dispatched and that arrangements were going to be made to try and contact and out of hours doctor. Mr Gill collapsed and died shortly thereafter. The conclusion reached by [redacted] who is the 111 Clinical Quality and Nurse Lead for the NHS 111 Service of the North West Ambulance Service NHS Trust concluded that of the five calls only one was processed correctly. [redacted] concluded "we have identified that throughout the calls made to NHS 111 and UCD questions stems around vomiting blood/coffee ground vomit were poor. There was not much evidence of supporting information being used even though this is available within the pathways and the Manchester Triage question. Assumptions were made that the caller/patient understood the presentation of blood in vomit (ranging from bright red to dark brown or black). There was not much probing around the patient vomiting brown fluid or smelling of "poo". Since this incident we have requested a change to the vomiting and/or nausea pathway via NHS Pathways Issue log, in particular the question stem relating to vomiting blood or faeces. The question stem is misleading to health assistants in regard to having three parts. As yet we have had no response from NHS Pathways regarding this change.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving arise to concern. In my opinion there is a risk that further deaths will occur unless action is taken. In the circumstances it is my duty to report to you the **MATTERS OF CONCERN** being as follows: - That on four out of five telephone conversations between Mr Gill and his wife and NHS 111 only one call elicited the appropriate response. It would therefore appear that the vomiting pathways is not sufficiently robust to ensure an appropriate response.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 31st October 2016. I, the Coroner, may extend this 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 person, namely: [redacted] [redacted] North West Ambulance Service 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	**30 August 2016**	**Signed by:** ..... **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**