IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Karl James BOLAM
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • NHS Pathways, nhspathwaysclinicaldirector@nhs.net
1	**CORONER** Ms Anna Loxton, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Karl James BOLAM** was opened on 29th August 2018. It was resumed and evidence was heard on 7th June 2019 and 8th October 2020, when it was concluded. I found the medical cause of death to be: 1a. Subdural Haemorrhage 1b. Head Injury 1c. Fall I determined that Mr Bolam died from a head injury he sustained in a fall at his home address in the early hours of 14th August 2018. He first telephoned for an ambulance at 1.09am and placed two further calls to chase attendance at 2.07am and 2.21am but the ambulance did not attend until 3.42am and located Mr Bolam at 4.10am, by which time he was unconscious with a Glasgow Coma Score of 3/15.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bolam called 999 at 1.09am on the morning of 14th August 2018 stating; "I was a little bit drunk and I slipped and I split my head open."

	He was categorised as a Category 2 disposition (Emergency, potentially serious incident) by call handlers at South East Coast Ambulance Service (SECAmb), requiring an 18 minute maximum response time. Unfortunately due to demands on the service, including a major incident the previous day, paramedics did not attend his home until 3.42am, and located Mr Bolam unconscious in the back garden of his home address at 4.10am. Mr Bolam had called 999 again at 2.07am and 2.21am stating that he felt worse, and welfare calls were made by a Clinical Supervisor from SECAmb at 1.14am and 1.37am. Mr Bolam was taken by air ambulance to Kings College Hospital where he was found to have very poor prognosis and he died on 17th August 2018 without having regained consciousness.
5	**CORONER'S CONCERNS** Mr Bolam resided with his friend and Landlord at his home address, who was unaware of Mr Bolam's accident and resulting head injury until paramedics attended at 3.42am on the morning of 14th August 2018. He was therefore unable to offer any assistance to Mr Bolam although willing to do so had he been aware. I heard evidence that SECAmb were in purple surge management plan at the time, meaning the service was unable to meet operational demand. Calls between Mr Bolam and the call handlers and Clinical Supervisor from SECAmb were played at the Inquest, and Mr Bolam stated that he was on his own. I heard that he was not asked whether there was anyone he could contact to be with him, particularly noting the long delay in paramedics being able to attend. I was advised by SECAmb that the questions asked by their operators are set by NHS Pathways, but that they intended to raise this issue for NHS Pathways to consider amending their scripts to positively advise lone callers to call someone to be with them. SECAmb updated the Court with the response from NHS Pathways on 8th December 2020 as follows:- ***NHS Pathways has made changes in relation to the ambulance closing instructions provided to first party callers that are alone. An additional instruction was inserted for Release 19.2 regarding calling someone else as follows – "If you do need to contact somebody do so now, then try and keep the line free as we may need to call you back".*** ***With regards to this case, no additional changes have been identified from the information provided. We are unclear as to what the ask is, nor who is responsible for taking this further. NHS Pathways has provided an email correspondence address for the coroner to raise any questions or queries.***

	In the meantime, this issue will be closed due to the changes made in Release 19.2. I do not believe this issue has been adequately addressed by the amendment in Release 19.2, and that the script provided by NHS Pathways for use with emergency callers should be amended positively to persuade callers to call someone to be with them, and particularly when a delay in paramedic attendance is anticipated. SECAmb have also expressed disappointment with this response. The **MATTERS OF CONCERN** are: 1. The script currently used by NHS Pathways in respect of emergency callers does not positively persuade callers to call someone to be with them, particularly in circumstances where paramedic attendance is delayed due to demands on the service. Consideration should be given to whether any steps can be taken to address the above concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. See names in paragraph 1 above 2. [redacted] 3. [redacted], Head of Legal Services, South East Coast Ambulance Service NHS Foundation Trust 4. The Chief Coroner

	In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: **ANNA LOXTON** **DATED this 14th day of January 2021**