HM Coroner
County of Cumbria
Regulation 28

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted], Clinical Director Covid-19 Pandemic Response Service** **[redacted], Deputy Clinical Director (NHS Pathways)**
1	**CORONER** I am Dr Nicholas Shaw, HM Assistant Coroner for **County of Cumbria**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 03/12/2020 I Opened an inquest into the death of Patricia Ann Douglas who died aged 76 on 28/9/20. It is hoped a full hearing will take place early in the new year.
4	**CIRCUMSTANCES OF THE DEATH** **Mrs Douglas contacted the NHS 111 service at 11.49 on Sunday 27/9/20 complaining of severe breathlessness, and reporting that she had experienced similar symptoms 2 weeks previously and had been very anaemic requiring a blood transfusion. The call handler's questioning took her down a route that ended in a suspicion that the symptoms may be due to Covid-19 and Mrs Douglas was informed that a doctor from the Covid Clinical Assessment service (CCAS) would call her back. A General Practitioner working for CCAS did try to contact Mrs Douglas 3 times between 13.30 & 13.38 but was unable to do so, believing the patient's phone to be engaged when in fact her telephone number had not been fully recorded on the referral passed from NHS 111. No further action was taken "Call closed as per protocol". Mrs Douglas and her husband waited all day for the call back. The following day her condition was worsening, her GP was contacted who arranged an emergency ambulance. Mrs Douglas was taken to A&E in Carlisle, arriving at 10.03, severely unwell, she collapsed during initial assessment and could not be resuscitated. Post mortem severe coronary atherosclerosis and a complete blockage of one artery was found, she tested negative for Covid-19.**
5	**CORONER'S CONCERNS** During the course of the initial inquiries 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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The initial assessment by the NHS 111 call handler led her down a pathway leading to a referral to the Covid service and does not seem to have given weight to the history of anaemia and transfusion. Could the pathway be improved to give better guidance to call handlers? (2) The call was closed by CCAS without further action due to an incorrect telephone number being recorded. The call was from an elderly lady who on the face of it seemed significantly unwell. Would

	referrals in similar circumstances to local providers [GP or out of hours services] who may be better placed to follow up be worth considering? (3) This lady rang for help feeling very unwell, I am told she wanted a doctor to visit, unfortunately nothing happened and it seems very likely that an opportunity to investigate and treat her was missed. I note that two GPs would have been working for the OOH provider at Penrith Hospital –just a mile from Patricia's home, that Sunday afternoon, one based in the hospital and the other doing home visits.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisations 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 10th February 2021. 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 Person [redacted] (Patricia's son). I have also sent it to [redacted] (Medical Director, Cumbria Health On Call) and [redacted] (Patricia's GP) 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	16/12/2020 Dr Nicholas Shaw, HM Assistant Coroner **County of Cumbria**