REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health
1	CORONER I am Alison Mutch Senior Coroner, for the coroner area of South Manchester
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 16th September 2019 I commenced an investigation into the death of Joan Margaret McIndoe. The investigation concluded on the 22nd June 2020 and the conclusion was one of **Natural Causes.** The medical cause of death was **1a) Acute left ventricular failure; 1b) Ischaemic heart disease; 1c) Coronary artery atheroma**
4	CIRCUMSTANCES OF THE DEATH Joan Margaret McIndoe resided at 33 Mayfair Court, a retirement complex. In office hours from Monday - Friday there was an on-site manager. Out of hours there was an alarm system in operation. On 14th September 2019 at 05:39 the alarm in her flat was activated. The call centre monitoring the alarm was unsuccessful in making contact with her and the Ambulance Service was contacted. The call was categorised as a category 4 call in accordance with national policy regarding calls of this type. There was no follow up by the call centre. Her family were notified of the activation and that an ambulance had been called. At about 07:30 her family attended and found her unresponsive in the shower. A further call was placed to NWAS who responded immediately. They pronounced her dead on their arrival after carrying out an assessment.

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. The inquest was told that all such calls as this from residential facilities where contact cannot be established with the resident are automatically categorised as a Category 4 response by the ambulance service. This is in contrast to where a call is initiated and then contact is lost during the call. 2. During the course of the inquest evidence was given that there is a lack of clarity about expectations for updates once a call has been placed by a call centre to the ambulance service. As a result there is no way of understanding if the position is evolving for example as in this case where the alarm kept going off and there was still no response from Mrs McIndoe.
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 26th August 2020. 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, namely Mr [redacted] son of the deceased, 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	**Alison Mutch OBE** **HM Senior Coroner** **01.07.2020**