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IN THE CORONERS COURT IN NORTHERN IRELAND

_____

BEFORE THE CORONER OF NORTHERN IRELAND

MARIA DOUGAN

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IN THE MATTER OF AN INQUEST TOUCHING UPON THE DEATH OF LEE GANNON

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Appearances

Ms Niamh Horscroft (instructed by Ms Rosalind Johnston, Coroners Service for Northern Ireland); on behalf of the Coroner

Mr Michael Lavery BL (instructed by Ms Catherine McReynolds, Directorate of Legal Services); on behalf of the Northern Ireland Ambulance Service (NIAS)

Mr Mark Bassett BL, instructed by Mr Colin McMenamin, KRW Law, on behalf of the Next of Kin

Introduction

1. The inquest proceeded in Laganside Courts on 15 and 16 September 2025. During the inquest, I received evidence from a number of witnesses, and I carefully considered further statements, together with voluminous notes, records and reports which were admitted pursuant to Rule 17 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963. While it is not feasible to set out all the

evidence in these findings, I wish to make clear that I have duly considered all evidence presented before reaching my conclusions.

2. The deceased, Lee Gannon, born on 11 September 1996, from the Beechmount area, Belfast, died on 15 February 2022 in the Royal Victoria Hospital, Belfast.

Summary of events

3. The deceased, aged 25 years, had been unwell for several days prior to 14 February 2022. Family members described him as complaining of feeling cold and being generally unwell. On the evening of 14 February 2022, his condition deteriorated and he developed increasing shortness of breath, confusion and a deterioration in his overall condition.

4. At 00.19 hours on 15 February 2022, the Northern Ireland Ambulance Service ('NIAS') received a 999-call requesting assistance for the deceased. The call was categorised as a Category 2 response. During the following hours, a further three 999 calls and a clinical support callback occurred as the deceased's condition deteriorated. Information provided during those contacts included reports that he was struggling to breathe, had not been eating, was hallucinating, was behaving unusually, was becoming less responsive and had developed rolling eye movements.

5. At approximately 03.38 hours, during a callback from the NIAS Clinical Support Desk, it was reported that the deceased was no longer breathing. The incident was upgraded to a Category 1 response and cardiopulmonary resuscitation was commenced by family members with the assistance of telephone instructions provided by NIAS.

6. Paramedics arrived at the address at approximately 03.43 hours and found the deceased in cardiac arrest. Advanced life support measures were commenced and continued at the scene. As no return of spontaneous circulation was achieved, he was conveyed to the Royal Victoria Hospital with ongoing resuscitation efforts.

7. The deceased arrived at the Royal Victoria Hospital at approximately 04.13 hours. Despite ongoing resuscitative efforts, he was pronounced dead at 04.43 hours on 15 February 2022.

8. A post-mortem examination identified established right-sided lobar pneumonia as the cause of death.

Scope of the Inquest

9. It is well-established that an inquest is a fact-finding exercise. It does not determine civil or criminal liability. The applicable standard of proof is the civil standard, namely the balance of probabilities.

10. A provisional scope document was provided to the Properly Interested Persons (PIPs) prior to the commencement of the inquest. Submissions seeking a widening of the scope were made on behalf of the Next of Kin and were considered by me. Whilst additional disclosure was directed, no amendment was made to the scope at that stage. As is invariably the case, the scope remained provisional and was kept under review throughout the hearing.

11. The scope document read as follows:

> *"The purpose of an Inquest is to allow the Coroner to answer the statutory questions as outlined in Rule 15 of the Coroners (Practice and Procedure) Rules Northern Ireland 1963. This requires the Coroner to ascertain:*
>
> 1. *Who was the deceased?*
> 2. *How, when and where the deceased came by their death?*
>
> *The deceased has been identified as Lee Gannon and there is no dispute about this identification. The Inquest will therefore focus on identifying how, when and where Mr. Gannon came by his death.*
>
> *The purpose of an Inquest is not to attribute criminal or civil liability to any individual or body. However, in relation to the question of "how" he came by his*

death, the Coroner will consider whether any person or persons act or omission caused the death of Mr. Gannon.

The purpose of the Inquest is to answer the four statutory questions set above."

12. I am satisfied that this inquest has addressed all relevant issues and that, where possible, I have reached findings in respect of the matters which fall within the scope of this inquest.

Review of the Evidence

Anne Gannon

13. Ms Anne Gannon, mother of the deceased, gave evidence to the inquest. Ms Gannon explained that at approximately 22.00 hours on 14 February 2022, the deceased complained of feeling unwell and appeared pale. When asked whether he wished an ambulance to be called, he declined. By approximately 23.00 hours, Ms Gannon observed a marked deterioration in his condition. She described him as disorientated, stated that he could not breathe and observed that his eyes were rolling. Concerned by this deterioration, the deceased's father, Mr Colum Wilson, contacted NIAS at approximately 00.19 hours.

14. Ms Gannon took over the call and told the call handler that the deceased was "barely breathing", that he could "barely get his words out" and that he was talking "gibberish". She recalled being advised that the incident was an "A1 priority" call. She contacted NIAS a second time at approximately 00.31 hours because the deceased's condition was worsening. During that call she reported that "his breathing's getting worse", that he was "acting out" and "panicking" and that this behaviour was not normal for him. She was informed that it remained a high-priority call but that no ambulance was currently available and that a resource would need to be released from hospital. She was asked whether the deceased could be brought to hospital by alternative means but stated that he could not. Ms Gannon explained in oral evidence that the family were frightened to move him and were in shock because of the severity of his

condition. Ms Gannon told the inquest that she lived only a short distance from the Royal Victoria Hospital, describing it as a "stone's throw" away, approximately four minutes by car.

15. During a third call at approximately 02.01 hours, Ms Gannon informed the call handler that the deceased's breathing was "very very short", that he was hallucinating and that "his eyes are like rolling in the back of his friggin head". She further reported that he could not talk. She was advised that ambulance crews remained unavailable and that NIAS was awaiting resources to clear from hospital. During a fourth call at approximately 03.26 hours, she reported that the deceased was "getting worse by the minute", that his eyes were "rolling to the back of his head", that he was acting unusually and that he was no longer behaving normally. She repeatedly asked that an ambulance attend urgently.

16. At approximately 03.38 hours on 15 February 2022, a clinician from the NIAS Clinical Support Desk telephoned Ms Gannon to undertake further clinical assessment. She informed them that the deceased had stopped breathing and could not be awakened. She was instructed to commence CPR. The deceased's father carried out chest compressions whilst remaining in telephone contact with NIAS. Ms Gannon stated that the deceased was limp and unresponsive throughout this period. CPR was continued until paramedics arrived and thereafter whilst resuscitation efforts continued. She subsequently observed ambulance personnel continuing treatment as the deceased was removed from the property. Ms Gannon stated that she knew by this stage that the deceased was gone as he was limp and did not respond to CPR.

17. Ms Gannon told the inquest that although the deceased was generally well, he had experienced an addiction to painkillers, specifically Nurofen Plus, for approximately four years. She recalled that he had recently been unable to keep food down and was due to attend the Royal Victoria Hospital on 15 February 2022 for investigations relating to ongoing stomach problems.

18. In oral evidence, Ms Gannon stated that the deceased had appeared generally unwell for approximately three to four days prior to his death and had repeatedly complained of feeling cold. She initially believed that he may have been developing flu or another minor illness. She stated that she did not become aware of any breathing difficulties until the evening of 14 February 2022 when the deceased came into the living room, appeared unwell and informed her that he could "barely breathe". She described his condition as deteriorating steadily throughout the night.

19. Ms Gannon described how she was repeatedly reassured that an ambulance would attend. She explained that she did not believe it would have been safe or possible to transport the deceased to hospital because of the severity of his condition, his confusion and her concern that moving him might cause further harm.

20. Ms Gannon described the deceased as a "mummy's boy", "lovable and funny" and a "beautiful child, beautiful soul". She stated that he remained very close to his family and continued to live at home. She recalled him as kind, humorous and "loved by everybody", and described the profound loss his death had caused to the family.

Colum Wilson

21. Mr Colum Wilson, the deceased's father, gave evidence to the inquest. He stated that, by around midnight on 15 February 2022, the deceased's condition had deteriorated to the extent that he contacted NIAS. Mr Wilson initially spoke to the call handler but handed the telephone to Ms Gannon whilst he remained with the deceased, who had become increasingly distressed, disorientated and short of breath. Mr Wilson understood that the incident had been categorised as a priority call.

22. Mr Wilson described waiting approximately four hours for ambulance attendance whilst the deceased's condition continued to deteriorate. During this period, the family made repeated calls to NIAS seeking updates regarding the

arrival of an ambulance. He stated that, by the time of the final contacts with NIAS, the deceased had become increasingly unwell, was no longer behaving normally, had become unresponsive and his eyes had rolled back.

23. Mr Wilson was instructed to commence CPR and carried out chest compressions before paramedics arrived and took over resuscitation efforts. He stated that the deceased remained unresponsive throughout the period during which he administered CPR and remained so following the arrival of paramedics. The deceased was subsequently conveyed to the Royal Victoria Hospital, where Mr Wilson later learned that he had died.

24. In oral evidence, Mr Wilson stated that the deceased had appeared generally unwell for several days before his death, primarily complaining that he felt cold. He stated that the first complaints of breathing difficulties arose on the evening of 14 February 2022 when the deceased became increasingly distressed and complained that he could not breathe. He described the deceased as becoming progressively more disorientated and deteriorating throughout the night.

25. Mr Wilson stated that he remained with the deceased whilst Ms Gannon communicated with NIAS. He explained that he did not believe it would have been possible to transport the deceased to hospital because of his distress, confusion and physical deterioration.

26. Mr Wilson described the deceased as a source of enormous pride and stated that he had been a pleasure to have as a son. He spoke movingly of the continuing impact of the deceased's death upon the family and told the inquest that he thought about him every day.

<u>999 calls and associated NIAS records</u>

27. The audio recordings of each of the five telephone contacts made with NIAS during the early hours of 15 February 2022 were played during the inquest hearing. These comprised the initial 999 call handled by Ms Zena Gardener, subsequent calls handled by Ms Andrea Hunter, Ms Clare Mercer and Mr James

Bryant, and the clinical support callback by Mr Mark Cameron immediately preceding the commencement of CPR. The Court was also provided with transcripts of each of those calls. Following the death of the deceased, NIAS conducted a Serious Adverse Incident (SAI) Review investigation. The handling of the emergency calls was also subjected to both internal (NIAS) and external (International Academies of Emergency Dispatch (IAED)) audit as part of that process.

28. The first 999 call was made at approximately 00.19 hours and was answered by Ms Gardener. During that call, the caller, initially Mr Wilson and subsequently Ms Gannon, reported that the deceased was "finding hard to breathe", was "barely breathing", had not been eating, could "barely get his words out" and was repeatedly saying that he could not breathe. Ms Gannon further described him as talking "gibberish", appearing white and clammy and being unable to "get a breath out properly". In response to questions posed by the call handler, she stated that the deceased was talking to her but only "barely". The call handler asked a series of questions regarding breathing, alertness and possible Covid-19 symptoms, advised that help was being arranged, instructed that the deceased should not be given anything to eat or drink and advised Ms Gannon to monitor him closely and to contact NIAS immediately if he became less awake, began vomiting or deteriorated further.

29. A second call was made at approximately 00.31 hours and was answered by Ms Hunter. During that call, Ms Gannon informed NIAS that the deceased's "breathing's getting worse". She reported that he was "acting out", that he was "panicking" and that this behaviour was not normal for him. The call handler informed her that the incident remained a high-priority call but that no ambulance resource was then available and that a vehicle would need to be released from hospital. Ms Gannon was asked whether the deceased could be brought to hospital by alternative means and replied that this was not possible because he was not himself and could not be transported. She was advised that

NIAS was dealing with a large number of emergency calls and was told to contact the service again if his condition worsened.

30. A third call was made at approximately 02.01 hours and was answered by Ms Mercer. During that call, Ms Gannon reported that the deceased's breathing was "very very short", that he was hallucinating and that "his eyes are like rolling in the back of his friggin head". She further stated that he was no longer able to talk properly, saying "he can't even talk", and indicated that she did not know whether he had "dosed off". The call handler asked whether the deceased remained alert and whether he would open his eyes if prompted. Ms Gannon responded that she did not know whether he had drifted off and repeated that he could not speak. The call handler informed her that the incident remained classified as an emergency but that ambulance crews were still unavailable and that NIAS was waiting on crews clearing from hospital. She was advised to continue monitoring the deceased closely and to telephone again if there were any further changes in his condition.

31. A fourth call was made at approximately 03.26 hours and was answered by Mr Bryant. During that call, Ms Gannon reported that the deceased was "getting worse by the minute". She stated that he was not eating or drinking, was severely dehydrated, was acting unusually and that "his eyes are rolling to the back of his head". She described him as delusional, stated that he did not know what was going on and reported that he was "rolling about the floor". She told the call handler that his cheekbones were "all sunk in" and repeatedly requested that an ambulance attend. During the call, the call handler undertook further questioning regarding the deceased's condition, repeatedly reassured Ms Gannon that help was being arranged and explained that NIAS was experiencing exceptional demand. He again enquired whether the deceased could be transported to hospital independently and was informed that this was not possible. Towards the end of the call, Ms Gannon reported that the deceased was not responding to her, was "rolling about the floor" and appeared "grey". The call handler informed her that no ambulance resource was currently

available, explained that the service was "absolutely overwhelmed" and arranged for a clinician from the Clinical Support Desk to telephone the family.

32. At approximately 03.38 hours, Mr Cameron from the NIAS Clinical Support Desk telephoned the family. During that call, it was reported that the deceased could not be awakened and was no longer breathing. Ms Gannon repeatedly requested that an ambulance attend immediately. The incident was immediately escalated, a Category 1 response was generated, and CPR instructions were provided by NIAS.

33. The Court also considered the contemporaneous NIAS call management records and Medical Priority Dispatch System ("MPDS") records generated during the handling of those calls. These records documented the information provided by family members, the categorisation and re-categorisation of calls, the allocation status of ambulance resources and the contemporaneous actions of call handlers and control staff.

34. The recordings, transcripts and associated NIAS records were referred to extensively throughout the oral evidence. They enabled the Court to consider not only the evidence of individual witnesses but also the precise information available to NIAS at each stage of the deceased's deterioration and informed the Court's assessment of the evidence.

Zena Gardener

35. Ms Zena Gardener, an Emergency Medical Dispatcher with the Northern Ireland Ambulance Service, gave evidence to the inquest. She explained that her role was to receive 999 calls, process the information provided by callers and offer advice and instructions appropriate to the patient's condition. She had been employed in that role since December 2019 and undertook her Emergency Medical Dispatcher training between September and December 2019.

36. Ms Gardener stated that she received the initial 999 call concerning the deceased at approximately 00.19 hours on 15 February 2022. The caller, initially Mr Wilson

and subsequently Ms Gannon, reported that the deceased was finding it difficult to breathe, was "barely breathing" but remained awake. Ms Gannon further reported that the deceased had not been eating, could "barely get words out", was repeatedly saying that he could not breathe, was talking "gibberish", appeared white and clammy and could not "get a breath out properly".

37. During the call, Ms Gardener asked questions in accordance with the MPDS protocol then in use. When she asked whether the deceased was completely alert, Ms Gannon initially responded that he was "gibberish". When the question was repeated, Ms Gannon stated that the deceased was talking to her but only "barely". Ms Gardener then asked a series of questions relating to Covid-19, which formed part of the protocol being used at that time. She advised Ms Gannon that help was being arranged, that the deceased should not be given anything to eat or drink and that he should be closely monitored pending ambulance attendance. She further advised that NIAS should be contacted again if the deceased became less awake, began vomiting or otherwise deteriorated. The call lasted approximately four minutes and fifteen seconds.

38. In oral evidence, Ms Gardener explained that the first question asked in every emergency call is whether the patient is breathing. She stated that if the answer is no, no further triage questions are asked, the caller's address is obtained immediately, CPR instructions are commenced, a Control Officer is informed, and a Category 1 response is generated. She explained that a Category 1 response carries an eight-minute target response time and permits ambulance resources to be diverted from lower-acuity calls and protected meal breaks interrupted in order to achieve the fastest possible response. She contrasted this with a Category 2 response, which carries an eighteen-minute target response time and does not permit the same escalation measures. She further explained that, when answering the initial breathing question, there was an option to record that a patient was breathing but that the breathing was ineffective and that such a coding would generate a Category 1 response. She stated that the second question asked is whether the patient is awake and that the answers

given to these initial questions determine the subsequent questions asked through MPDS and direct the remainder of the triage process.

39. Ms Gardener stated that she processed the call using Protocol 36, which denoted pandemic/epidemic outbreak. She explained that, during the Covid-19 pandemic, callers reporting symptoms such as shortness of breath, chest pain, headache or general illness were directed through Protocol 36 because that protocol incorporated the Covid-19 screening questions then required. She stated that she categorised the call as a Category 2 response under Protocol 36 on the basis of the breathing difficulties being reported by Ms Gannon.

40. Ms Gardener accepted that she had received training regarding ineffective breathing during her initial Emergency Medical Dispatcher training and that such training formed part of the certification process. She confirmed that the training included scenario-based exercises and covered circumstances in which callers might describe ineffective rather than absent breathing. She further confirmed that she undertook periodic recertification and refresher training.

41. Following the deceased's death, the handling of the call was subjected to both internal and external audits. The Northern Ireland Ambulance Service Control Training and Quality Improvement Unit conducted an internal audit of the call, whilst a further independent audit was obtained from the International Academies of Emergency Dispatch, of which NIAS is a member. The call was also examined as part of the NIAS SAI Review investigation.

42. In oral evidence, Ms Gardener accepted the findings of both the internal and external audits which determined that the categorisation was incorrect and that the call should have received a Category 1 response. She agreed that the call should have been categorised as a Category 1 response. She accepted that Ms Gannon's description of the deceased as "barely breathing" ought to have resulted in the ineffective breathing option being selected and that Protocol 6 (ineffective breathing), rather than Protocol 36, should have been used. She accepted that this would have generated a Category 1 response from the outset

and would have triggered the dispatch procedures available for Category 1 incidents. When asked whether she agreed that the information provided by Ms Gannon should have resulted in a Category 1 categorisation, she replied, “It should have been a Category 1, yes.”

43. Ms Gardener also accepted the audit findings concerning alertness. She acknowledged that Ms Gannon's responses, including that the deceased was “gibberish” and was talking only “barely”, should have been interpreted differently. She accepted the external audit conclusion that the best interpretation of those responses was “no”, as a definitive positive response regarding the deceased's alertness had not initially been provided. She accepted that the information available during the call was capable of supporting a Category 1 categorisation. The audit further concluded that Ms Gannon’s responses suggested the deceased was not completely alert and observed that “it seemed that the EMD wasn't accepting 'no' as an answer”. Ms Gardener accepted those findings.

44. Ms Gardener further accepted that it remained possible to revisit and reconsider responses previously entered during a call when new information emerged. She accepted that, following the initial breathing question, there were multiple further references to the deceased's breathing difficulties and that it would have been possible to reassess the original response. When asked why she had not done so, she stated that it would have been an “error” and a “misunderstanding”. She was similarly unable to explain why she had not revisited the response recorded in respect of the deceased's alertness.

45. Ms Gardener confirmed that, following the deceased's death, further guidance, bulletin updates and training regarding ineffective breathing were issued by NIAS. She stated that call handlers were provided with additional education and learning materials following the deceased’s death and confirmed that she agreed with the conclusions reached through the audit process.

46. Ms Gardener further described the significant pressures affecting ambulance availability both at the time of the deceased's events and currently. She explained that call handlers frequently had to speak to callers who had been waiting lengthy periods for ambulance attendance and repeatedly apologise for delays. When asked whether the position had improved since 2022, she stated that waiting times had become "worse". She explained that call handlers regularly have to ask callers whether patients who remain awake and breathing can make their own way to hospital because of the delays affecting ambulance availability. She described the position of call handlers as one where their "hands are tied" as they continue to explain delays to callers whilst working within the dispatch protocols and the operational escalation framework.

Andrea Hunter

47. Ms Andrea Hunter, an Emergency Medical Dispatcher with the Northern Ireland Ambulance Service, gave evidence to the inquest. She stated that she received the second 999 call concerning the deceased at approximately 00.31 hours on 15 February 2022. The call presented as a duplicate contact regarding the existing incident. In accordance with the procedure she was following at the time, she confirmed that the deceased remained conscious and breathing before reviewing the status of the original emergency call.

48. During the call, Ms Gannon enquired whether an ambulance was on its way and reported that the deceased's "breathing's getting worse". She further stated that he was "acting out", that he was "panicking" and that this behaviour was not normal for him. Ms Hunter checked the status of the existing incident and advised that no ambulance had yet been allocated. She informed Ms Gannon that the incident remained a high-priority call and that an ambulance would be assigned as soon as a resource became available. She further advised that significant delays were being experienced and that a vehicle would need to be released from hospital before attendance could occur.

49. Ms Hunter asked whether there was any possibility of transporting the deceased to hospital by alternative means. Ms Gannon responded that this was not possible, explaining that the deceased was not himself and could not be transported. Ms Hunter reiterated that an ambulance would be dispatched as soon as one became available, advised that NIAS was dealing with a high volume of life-threatening calls and informed Ms Gannon that she should contact the service again if the deceased's condition deteriorated further.

50. In oral evidence, Ms Hunter explained that she immediately recognised the call as a duplicate call because Ms Gannon was seeking an update regarding ambulance attendance. As a result, she checked the status of the original incident rather than commencing a fresh clinical assessment of the deceased. She accepted that she had discretion to re-triage the call if new information was provided and agreed that Ms Gannon's report that the deceased's "breathing's getting worse" should have prompted a fresh triage assessment.

51. Ms Hunter accepted the findings of both the internal audit and the NIAS SAI review that the call ought to have been re-triaged in accordance with protocol. She agreed that she should have stopped the duplicate call and commenced a new triage assessment. She accepted that, had she done so, further information regarding the deceased's condition may have been elicited and could have affected the categorisation of the incident. She accepted that she ought to have recommenced the triage process when informed that the deceased's breathing was deteriorating and stated, "based on that information, I should have re-triaged the whole call." When questioned about the audit findings, she stated, "in hindsight, looking back, I can say I definitely should have re-triaged that call" and "I do regret not re-triaging that call."

52. Ms Hunter explained that she had previously worked as an Emergency Medical Dispatcher with the National Ambulance Service in the Republic of Ireland and had completed her initial Emergency Medical Dispatcher training in 2018. On joining NIAS in October 2021, she undertook further training regarding local policies and procedures. She confirmed that her training included recognition of

ineffective breathing, operation of the MPDS system and the circumstances in which repeat callers should be re-triaged. She further confirmed that Emergency Medical Dispatchers undertake ongoing recertification and refresher training.

53. Ms Hunter stated that the information she provided regarding delays and the possibility of self-transport to hospital reflected the clinical safety plans and scripts then in operation within the control room. She explained that dispatchers were routinely required to advise callers of significant delays and, where clinically appropriate, ask whether patients could safely make their own way to hospital. She further explained that NIAS now uses additional clarifiers when dealing with duplicate calls and that reports of deterioration in a patient's condition now trigger a fresh triage assessment. She stated that these changes were introduced following learning identified from incidents such as this. She also stated that NIAS now has access to a dashboard providing estimated waiting times, which was not available at the time of the deceased's death. She accepted that, under the procedures now in place, a report that a patient's breathing was worsening would prompt a new triage assessment rather than simply a review of the existing call.

Clare Mercer

54. Ms Clare Mercer, an Emergency Medical Dispatcher with the Northern Ireland Ambulance Service, gave evidence to the inquest. Ms Mercer explained that she had only recently qualified as an Emergency Medical Dispatcher, having completed a twelve-week training programme and been signed off as competent in December 2021. She confirmed that her training included the recognition of ineffective breathing, use of the MPDS system and scenario-based learning.

55. Ms Mercer stated that at approximately 02.01 hours on 15 February 2022 she answered the third 999 call relating to the deceased. Ms Gannon advised that she had previously contacted the Ambulance Service and was seeking an update regarding ambulance attendance. Ms Mercer accessed the existing incident

record and asked whether there had been any change in the deceased's condition.

56. During the call, Ms Gannon reported that the deceased's breathing was "very very short", that he was hallucinating and that "his eyes are like rolling in the back of his friggin head". She further stated that she did not know whether he had "dosed off" and reported that "he can't even talk". Ms Mercer reviewed the existing incident, confirmed that the deceased had previously been reported as short of breath and not eating and updated the incident record with the additional information provided by Ms Gannon.

57. Ms Mercer advised Ms Gannon that the incident remained an emergency call but that no ambulance crews were currently available and that NIAS was waiting on crews clearing from hospital. She informed Ms Gannon that she did not have any further update concerning ambulance attendance and advised her to continue monitoring the deceased closely and to telephone again if there were any further changes in his condition.

58. Ms Mercer stated that she was now aware that she had not completed the call in accordance with NIAS policy and that "a new call should have generated as per protocol". She further stated that, following feedback and review of the relevant standard operating procedure, it had been reiterated that all duplicate calls must be processed as a new call and that she now follows that procedure.

59. Ms Mercer accepted that she had discretion to re-triage the call and agreed that, in light of the information provided by Ms Gannon, re-triage should have occurred. She accepted that Ms Gannon was providing new clinical information concerning the deceased's deteriorating condition and that the repeat contact should have been processed as a new call. When asked about the information reported during the call, she accepted that "based on that information" she "should have re-triaged the whole call" and that her failure to re-triage the incident was an error.

60. Ms Mercer further accepted that the symptoms reported during the call, including "very very short" breathing, inability to speak, reduced responsiveness, uncertainty as to whether the deceased had "dosed off" and rolling eye movements, were capable of indicating ineffective breathing and reduced alertness. She accepted that, had ineffective breathing been identified through a fresh triage process, a Category 1 response would have been generated. She was aware that the incident was at that time categorised as a Category 2 response. She further accepted that the subsequent NIAS internal review correctly concluded that the deceased ought to have been re-triaged through the MPDS system.

61. Ms Mercer stated that she was aware of the significant pressures affecting ambulance resources at the time and knew that substantial delays to ambulance attendance were occurring. She also accepted that Category 2 calls were frequently not receiving responses within the expected response time of eighteen minutes. She stated, "everyone was under pressure, we were trying to get out to people as much as we could and be as compassionate and apologetic to callers". However, she maintained that those operational pressures did not influence her decision not to re-triage the call and stated that the failure to do so was not connected to ambulance availability but arose from her handling of the call itself.

62. Ms Mercer further explained that additional guidance and training regarding ineffective breathing and the handling of duplicate calls had since been introduced. She stated that all duplicate calls are now required to be processed as new calls and that she follows that procedure in her current practice. Referring to the learning arising from the call, she stated, "I do re-triage every call and it's a regret of mine that I didn't do this and it could have had a better impact for the family."

<u>James Bryant</u>

63. Mr James Bryant, an Emergency Medical Dispatcher with the Northern Ireland Ambulance Service, gave evidence to the inquest. He qualified as an Emergency

Medical Dispatcher in November 2019. In September 2022, he obtained the qualification of Quality Assurance Auditor from the International Academies of Emergency Dispatch.

64. Mr Bryant stated that at approximately 03.26 hours on 15 February 2022 he received the fourth 999 call concerning the deceased. Ms Gannon advised that they had already contacted NIAS on a number of occasions and reported that the deceased was "getting worse by the minute". She stated that he was severely dehydrated, was behaving unusually and that his eyes were "rolling to the back of his head".

65. Mr Bryant reviewed the existing incident record and confirmed with Ms Gannon that the information already recorded, namely that the deceased was short of breath and had not been eating, remained correct. He was aware that a high priority call already existed and that ambulance attendance was still awaited.

66. During the call, Ms Gannon reported that the deceased was not eating or drinking, was severely dehydrated, was "acting out", was not behaving normally and appeared confused and disorientated. She stated that he did not know what was going on and was "rolling about the floor". She further reported that his cheekbones were "all sunk in".

67. In response to the information received from Ms Gannon and the reported change in condition, Mr Bryant undertook a further triage assessment through MPDS Protocol 25, which at the relevant time related to psychiatric presentations, abnormal behaviour and suicide attempts.

68. Mr Bryant explained that he selected Protocol 25 because the new information being reported by Ms Gannon related principally to abnormal behaviour and altered responsiveness. He stated that he remained aware that a breathing-related call of a higher priority already existed and that his intention was to obtain additional information about the deceased's changing presentation rather than replace the existing categorisation. He explained that the protocol generated a lower response category than the extant call, namely a Category 3

response, and that he therefore closed it as a duplicate, with the original higher-priority categorisation remaining in place.

69. Mr Bryant explained the position regarding ambulance availability to Ms Gannon and advised that the Ambulance Service was experiencing exceptional demand. He again explored whether the deceased could be transported to hospital independently but was informed that this was not possible. He advised that NIAS would continue to seek an ambulance response.

70. Towards the conclusion of the call, Ms Gannon reported that the deceased was "rolling about the floor", was not responding appropriately to her and appeared "grey". She repeatedly requested that an ambulance attend immediately. Mr Bryant informed her that no ambulance resource was available at that time. In evidence, he stated that the service was "absolutely overwhelmed" and explained that the delays being experienced reflected the exceptional demand upon the service that night.

71. In oral evidence, Mr Bryant stated that the concerns expressed by Ms Gannon, together with the evolving description of the deceased's condition, led him to consider that further clinical assessment was required. He therefore referred the matter to the Clinical Support Desk, believing that a clinician would be better placed to undertake a more detailed assessment and provide additional advice whilst an ambulance response remained outstanding. He stated that the referral arose because Ms Gannon had made it clear that there was "something very serious going on" and because more than one clinical issue appeared to be present.

72. Mr Bryant accepted the findings of the subsequent audit. He noted that the audit concluded that he had correctly re-triaged the additional information through Protocol 25 and correctly closed the call as a duplicate when it generated a lower response category than the existing incident. However, he accepted the audit finding that, when Ms Gannon reported that the deceased was no longer responding appropriately to her, it would have been appropriate to clarify

whether he remained conscious. Mr Bryant acknowledged that this represented a learning point arising from the review of the call and accepted that this further clarification was not sought.

73. Mr Bryant stated that, shortly after the referral to the Clinical Support Desk was made, he became aware that the Clinical Support Desk had established that the deceased was no longer breathing and that CPR instructions were being provided to the family.

74. In oral evidence, Mr Bryant emphasised that the categorisation of calls was determined through the MPDS process and not by the availability of ambulances. He stated that, whilst he was aware of the significant delays affecting ambulance attendance and the exceptional pressure upon the service, those matters did not influence the categorisation of the incident.

Mark Cameron

75. Mr Mark Cameron, Clinical Support Manager and registered paramedic with the Northern Ireland Ambulance Service, provided a witness statement which was read into evidence under Rule 17. He stated that on 15 February 2022 he was working as a Clinical Support Paramedic within Emergency Ambulance Control.

76. Mr Cameron explained that he was contacted by an Emergency Medical Dispatcher, Mr Bryant, who had concerns regarding the deceased's condition and requested further clinical assessment. At approximately 03.38 hours, Mr Cameron telephoned the family.

77. During that call, Ms Gannon immediately informed him that the deceased was not breathing and could not be awakened. Having confirmed that information, Mr Cameron advised that CPR instructions would be provided without delay. He placed the call on hold, informed the relevant Control Officer that the incident required upgrading to a Category 1 response for a suspected cardiac arrest and tasked an Emergency Medical Dispatcher with providing CPR instructions to the family.

Eamonn Cunningham

78. Mr Eamonn Cunningham, a paramedic with the Northern Ireland Ambulance Service, gave evidence to the inquest. He stated that whilst on a rest period, at 03.39 hours on 15 February 2022 he was tasked to a Category 1 call at the deceased's address. He arrived at approximately 03.43 hours. On entering the living room, he found the deceased lying on the floor whilst Mr Wilson was performing chest compressions.

79. Mr Cunningham assessed the deceased as unresponsive, not breathing and without a pulse. Advanced life support was commenced. Intravenous access was obtained and advanced life support drugs were administered. A second ambulance crew attended shortly thereafter and assisted with the ongoing resuscitation effort.

80. Despite these interventions, the deceased remained pulseless and did not develop a shockable rhythm. Given the close proximity of the Royal Victoria Hospital, a decision was made to convey him to hospital whilst continuing resuscitative treatment. Whilst Mr Cunningham and his crewmate continued advanced life support at the scene, the second crew prepared the patient and ambulance for transport.

81. The ambulance left the scene at approximately 04.09 hours. Continuous chest compressions and ventilatory support were maintained throughout the journey. Mr Cunningham stated that throughout the resuscitation attempt and during transport the deceased remained without a pulse, respiratory effort or shockable cardiac rhythm. The ambulance arrived at the Royal Victoria Hospital Emergency Department at approximately 04.13 hours, where care of the deceased was transferred to Emergency Department staff and resuscitation efforts continued.

82. In oral evidence, Mr Cunningham explained that Mr Wilson was asked to continue chest compressions for a short period after ambulance arrival because uninterrupted chest compressions allowed paramedics to establish intravenous

access, airway management and other advanced life support interventions without delay. He stated that chest compressions could be performed by a bystander under instruction, whereas advanced life support interventions required trained ambulance personnel. He considered that asking Mr Wilson to continue CPR at that stage was the most effective way of providing care to the deceased and stated that it was "the correct decision to make". He further explained that this approach was consistent with accepted resuscitation guidance and policy issued by the Resuscitation Council UK.

83. Mr Cunningham also gave evidence regarding the effect of delayed hospital handovers upon ambulance availability. He stated that prolonged waits outside Emergency Departments had been "a regular feature" of his career since qualifying as a paramedic in April 2021. By way of example, he told the inquest that, on the day prior to giving evidence, he had spent approximately ten hours waiting outside the Ulster Hospital before being able to hand over a patient.

Dr George Graham

84. Dr George Graham, Registrar in Emergency Medicine, provided a witness statement which was admitted into evidence pursuant to Rule 17. He was the Emergency Department lead involved in the resuscitation of the deceased following his arrival at the Royal Victoria Hospital on 15 February 2022.

85. The deceased was in asystolic cardiac arrest and had received five doses of intravenous adrenaline prior to arrival. On arrival in the Emergency Department, resuscitative efforts continued in accordance with Advanced Life Support guidelines. The deceased's supraglottic airway device was replaced with an endotracheal tube by anaesthetic staff.

86. Dr Graham recorded that the deceased remained in asystole throughout. A further six doses of intravenous adrenaline were administered and there were no signs of life at any stage. Following discussion amongst the treating team, and with the agreement of the supervising Emergency Medicine Consultant, a

decision was taken to discontinue resuscitation efforts. Ms Gannon was updated regarding the situation and was present when resuscitation was discontinued.

87. Resuscitation was formally terminated and life was pronounced extinct at 04.43 hours on 15 February 2022.

Pathology evidence

Dr Marjorie Turner

88. Dr Marjorie Turner, Assistant State Pathologist for Northern Ireland, gave evidence to the inquest. She conducted an autopsy on the deceased on 17 February 2022 and thereafter produced a report. Dr Turner explained that the post-mortem examination identified an established right-sided lobar pneumonia. Microscopic examination confirmed the presence of pneumonia and also identified features consistent with systemic sepsis, including liver damage and likely secondary thrombi in some pulmonary arteries. She commented that such pneumonias can be very serious and fatal infections, even in otherwise healthy adults.

89. Testing for Covid-19 and influenza was negative. Bacteriological investigations identified isolates of *Staphylococcus aureus* and *E. coli*, either of which may have represented the infective organism, although both may also occur as post-mortem contaminants. There was no evidence of any other natural disease which caused or contributed to death. Old bilateral forearm scars consistent with previous self-harm were noted, but no significant injury was identified.

90. In oral evidence, Dr Turner stated that the pneumonia appeared well-established and was likely to have been present for a number of days prior to death. Whilst she could not identify a precise timeframe, she considered the reported history of illness over the preceding three days to be consistent with the pathological findings. She further stated that the deceased was of a very thin build and that poor nutritional status may have increased his susceptibility to infection. She

noted that, notwithstanding his reported history of Nurofen Plus misuse, she found no significant stomach pathology at post-mortem.

Expert Evidence

Dr Mohammad Al-Aloul

91. Dr Mohammad Al-Aloul, Consultant Respiratory Physician, was instructed on my behalf to prepare an expert report. He gave evidence to the inquest. Dr Al-Aloul concluded that the deceased's death resulted from pneumonia and sepsis leading to an out-of-hospital asystolic cardiac arrest. The post-mortem findings confirmed established lobar pneumonia together with features of systemic sepsis.

92. Dr Al-Aloul considered whether the deceased's history of Nurofen Plus misuse and associated gastrointestinal symptoms may have resulted in aspiration pneumonia. However, having reviewed the post-mortem findings, he concluded that there was no evidence of the gastrointestinal pathology which would be expected in such circumstances and that the deceased was suffering from community-acquired pneumonia.

93. Dr Al-Aloul stated that the deceased was underweight and accepted that a low body mass index may increase susceptibility to infection and adverse outcomes. However, he remained of the opinion that there was no significant underlying co-morbidity sufficient to explain or cause the deceased's death. He considered that the deceased had likely been suffering from pneumonia for several days prior to his death and that symptoms described by family members, including reduced oral intake, lethargy, confusion, disorientation and breathlessness, were consistent with that diagnosis. He stated that the deceased "would have been unwell for a few days before the final event".

94. Having reviewed the NIAS SAI review, Dr Al-Aloul noted that NIAS had concluded that the initial 999 call ought to have been categorised as a Category 1 response. He observed that, had the call been correctly categorised, existing

protocols would have facilitated a substantially earlier ambulance response and more rapid transfer to hospital. He stated, "there appears to have been nearly four-hour delay between the first request for emergency ambulance assistance and the NIAS response and transport to hospital. As a result, a 25-year-old man was denied the opportunity to receive prompt assessment, treatment and resuscitation for pneumonia and associated sepsis."

95. Dr Al-Aloul considered that, had a Category 1 response been generated following the initial 999 call, the deceased would likely have arrived at hospital by approximately 01.00 hours. He estimated that this would have provided a period of approximately two hours and forty-seven minutes before the point at which the deceased ultimately stopped breathing and suffered cardiac arrest. He considered that a competent Emergency Department team would have identified the deceased as critically ill and would have commenced oxygen therapy, intravenous fluids, intravenous antibiotics, urgent investigation and close monitoring in accordance with established sepsis pathways. Escalation to critical care would likely have followed if required.

96. Dr Al-Aloul explained that prompt implementation of the recognised sepsis care bundle, including oxygen therapy, intravenous fluids, intravenous antibiotics and appropriate organ support, is associated with a substantial reduction in mortality. He referred to published evidence demonstrating that delays in the treatment of severe sepsis are associated with worsening outcomes and stated that, in his opinion, the deceased's odds of survival would have been greatly enhanced by earlier assessment and treatment. He explained that this was particularly applicable in the case of a young man without significant co-morbidity.

97. In relation to the initial 999 call at 00.19 hours, Dr Al-Aloul stated that, on the balance of probabilities, the deceased would have survived had an ambulance attended and achieved either a Category 1 or Category 2 response time. He stated, "It is indeed probable" that the deceased would have survived following

a Category 1 response to the initial call and "it is still indeed, on the balance of probability, likely that he would have survived with a Category 2" response.

98. In relation to the second call at 00.31 hours, Dr Al-Aloul similarly considered it probable that the deceased would have survived had an appropriate Category 1 or Category 2 response been achieved.

99. In relation to the third call at 02.01 hours, Dr Al-Aloul stated that survival remained possible if intervention occurred at that stage. He considered that a Category 1 response at that point would still have been compatible with "a good chance of survival", although significantly less than after the first or second calls. However, he stated that a Category 2 response following the 02.01 hours call would, in his view, make survival less probable because the deceased was entering what he described as a "very, very critical narrow window for intervention".

100. In relation to the fourth call at approximately 03.26 hours, Dr Al-Aloul stated that he did not consider survival likely if ambulance attendance first occurred at that stage. He stated that "by that time the window of opportunity to intervene had passed and death, I think, was unavoidable at that stage".

101. Dr Al-Aloul concluded, "although pneumonia can be very serious and indeed fatal even in otherwise healthy adults, the inappropriate delay in ambulance arrival and transfer to hospital has contributed materially to his premature death, as it has denied him the opportunity of timely assessment and treatment which on the balance of probability was likely to save his life."

Conclusions on the evidence

102. I find, on the balance of probabilities, that the deceased's death on 15 February 2022 was preventable. The initial 999 call made on his behalf at 00.19 hours should have been categorised as a Category 1 response. Thereafter, as his condition continued to deteriorate, there were further missed opportunities at 00.31 hours and 02.01 hours to reassess and re-triage him and to secure an

appropriate ambulance response. As a result, the incident remained categorised as a Category 2 response and the deceased did not receive an ambulance response until after he had suffered a cardiac arrest. Had the initial call been correctly categorised and the subsequent opportunities for reassessment and re-triage been acted upon, I find, on the balance of probabilities, that the deceased would have received earlier ambulance attendance and transfer to hospital and that his death on 15 February 2022 would have been prevented.

103. On the evidence before the Court, I am satisfied that there were a number of missed opportunities in the handling of the deceased's emergency calls and in securing his earlier transfer to hospital. The findings which follow are made on the balance of probabilities.

The Initial 999 Call

104. I find that the information provided during the initial 999 call required a Category 1 response. In particular, the description of the deceased as "barely breathing" should have been recognised as ineffective breathing. Protocol 6, rather than Protocol 36, should have been used and the ineffective breathing option selected. That would have generated a Category 1 response. These matters were accepted by Ms Gardener in her evidence, including that the incident should have been categorised as Category 1 from the outset.

105. I find that the assessment of the deceased's alertness during the initial call was also incorrect. When Ms Gannon reported that the deceased was talking "gibberish" and could communicate only "barely", he should not have been recorded as completely alert. I find that the appropriate response to the question of whether he was completely alert was "no". Ms Gardener accepted that the information provided was inconsistent with the deceased being completely alert.

106. I find that, taken together, these errors meant that the NIAS triage process was not correctly applied during the initial call. The deceased's ineffective breathing was not recognised, the incorrect protocol was selected, and his reduced alertness was not properly identified. As further information concerning his

breathing and condition was provided during the call, the responses already entered should have been revisited. They were not. I find that these failures resulted in the deceased remaining incorrectly categorised as Category 2. Ms Gardener accepted in evidence that the responses could have been revisited as further information emerged and that the failure to do so was an error.

Subsequent Contacts with NIAS

107. I find that the second call at 00.31 hours should have been re-triaged as a new call. The deceased's breathing was reported to have worsened, and his behaviour was reported to be abnormal. This was new clinical information demonstrating deterioration and required a fresh triage assessment. I find that the duplicate call should have been stopped and a new triage commenced. That did not occur. Ms Hunter accepted in evidence that the call should have been re-triaged.

108. I find that the third call at 02.01 hours should also have been re-triaged as a new call. By then the deceased was reported to have very short breathing, to be hallucinating, unable to speak and exhibiting rolling eye movements, with uncertainty as to whether he had "dosed off". These were clear reports of further deterioration and required a fresh triage assessment. That assessment did not occur. Ms Mercer accepted that "a new call should have generated as per protocol", that the whole call should have been re-triaged and that her failure to do so was an error. Had ineffective breathing been identified upon that re-triage, a Category 1 response would have been generated.

109. In relation to the fourth call at approximately 03.26 hours, Mr Bryant undertook a fresh triage using Protocol 25, which generated a Category 3 response. As an existing Category 2 incident remained open, the lower-category incident was closed as a duplicate. I find that both the fresh triage under Protocol 25 and the closure of the resulting Category 3 incident as a duplicate of the existing Category 2 incident were appropriate. I find, however, that when it was reported that the deceased was no longer responding appropriately, further clarification should have been sought as to whether he remained conscious. I also find that

Mr Bryant appropriately referred the deceased for further clinical assessment when it had become apparent to him that there was "something very serious going on".

110. When the Clinical Support Desk contacted the family at approximately 03.38 hours, the deceased was unresponsive and no longer breathing. The incident was immediately upgraded to Category 1 and CPR instructions were provided.

111. I find that the information necessary to identify the deceased's deterioration was being provided contemporaneously to NIAS. The failures in the handling of the first three calls were failures to correctly apply the MPDS triage process to that information. Ineffective breathing was not recognised, concerns regarding alertness were not properly identified and the opportunities to undertake fresh triage assessments as the deceased deteriorated were not acted upon. Those failures were not caused by the operational pressures affecting ambulance availability.

Ambulance Availability

112. I find that NIAS was operating under very significant pressure on the night of the deceased's death. Ambulance availability was significantly affected by prolonged delays in handing patients over at Emergency Departments, with ambulance crews consequently unavailable to respond to emergency calls in the community.

113. I find that those operational pressures did not cause or influence the incorrect categorisation of the initial call or the subsequent failures to re-triage. They did, however, affect the availability of an ambulance whilst the deceased's call remained incorrectly categorised as Category 2.

114. The distinction between Category 1 and Category 2 was important. A Category 1 response carried an eight-minute target and engaged different escalation arrangements, including the ability to divert resources from lower-acuity calls, release ambulance crews delayed at Emergency Departments and, where

appropriate, interrupt protected meal breaks. Those escalation arrangements were not engaged whilst the deceased's call remained categorised as Category 2.

115. I find, on the balance of probabilities, that had the initial call been correctly categorised as Category 1, the escalation arrangements available for such a response would have been engaged and an ambulance would have been dispatched earlier, resulting in substantially earlier ambulance attendance and transfer of the deceased to hospital.

The Impact of the Delay

116. The deceased remained without ambulance attendance from the initial 999 call at 00.19 hours until approximately 03.43 hours, a period of approximately three hours and twenty-four minutes. Even on the incorrect Category 2 categorisation, for which the applicable target was eighteen minutes, no ambulance attended within that target or for more than three hours thereafter. I find that the deceased therefore received neither the Category 1 response which his condition required nor a timely response within the Category 2 categorisation which had incorrectly been assigned.

117. During that period the deceased's pneumonia and sepsis progressed and his condition continued to deteriorate until he suffered an out-of-hospital cardiac arrest. I accept Dr Al-Aloul's evidence that, had a Category 1 response followed the initial call, the deceased would have been expected to arrive at the Royal Victoria Hospital at approximately 01.00 hours, some two hours and forty-seven minutes before he ultimately stopped breathing.

118. I find that, had the deceased arrived at the Royal Victoria Hospital at that time, he would have been recognised as critically ill and would have received timely and appropriate treatment for pneumonia and sepsis. That treatment would have included oxygen therapy, intravenous fluids, intravenous antibiotics, urgent investigation and close monitoring, with escalation to critical care if required.

119. I find, on the balance of probabilities, that the deceased would have survived had an appropriate ambulance response followed either the initial 999 call or the second call at 00.31 hours. By 02.01 hours the position had changed. I accept Dr Al-Aloul's evidence that a Category 1 response at that stage would still have afforded the deceased a good chance of survival, although the window for effective intervention had narrowed significantly. By approximately 03.26 hours that window had passed and death was unavoidable.

120. I find that the incorrect categorisation of the initial 999 call and the subsequent failures to re-triage the deceased resulted in a substantial delay in ambulance attendance and transfer to hospital. That delay deprived the deceased of timely and appropriate assessment and treatment at the Royal Victoria Hospital for pneumonia and sepsis and materially contributed to his premature death.

Ambulance Response and Resuscitation

121. Once it was established at approximately 03.38 hours that the deceased was no longer breathing, the incident was immediately upgraded to Category 1, CPR instructions were provided and an ambulance was promptly dispatched. The ambulance crew arrived at approximately 03.43 hours and commenced advanced life support. I find that the response thereafter and the care provided by the ambulance personnel were appropriate.

122. I accept Mr Cunningham's evidence concerning the decision to permit the deceased's father to continue chest compressions briefly while the ambulance crew prepared the equipment required for advanced life support. I find that this allowed chest compressions to continue without interruption whilst the paramedics established the interventions requiring their clinical expertise and was appropriate resuscitative practice.

The Family

123. The deceased's family repeatedly sought emergency assistance as his condition deteriorated. They provided NIAS with updated information concerning his

condition and repeatedly requested urgent ambulance attendance. When asked whether the deceased could be transported to hospital by alternative means, they explained that, given his distress, confusion and physical deterioration, they did not consider that this could safely be done. I am satisfied that the information provided by the family was sufficient to enable the deceased's condition and deterioration to be appropriately assessed through the NIAS triage process.

Cause of Death

124. I accept the evidence of Dr Turner and Dr Al-Aloul. I find that the deceased was suffering from an established right-sided lobar pneumonia which progressed to systemic sepsis and ultimately resulted in an out-of-hospital cardiac arrest.

125. I find that there was no other natural disease which caused or materially contributed to the deceased's death. I have considered the evidence concerning his history of Nurofen Plus misuse, gastrointestinal symptoms and low body weight. Dr Turner found no significant gastrointestinal pathology at post-mortem and Dr Al-Aloul found no evidence to support aspiration pneumonia secondary to gastrointestinal disease. Whilst the deceased's low body weight may have increased his susceptibility to infection and adverse outcome, I find that neither his history of analgesic misuse nor his low body weight constituted a separate cause of death or materially contributed to it.

126. A post-mortem was performed, and it records, and I find that death was due to:

I(a) Lobar Pneumonia

Lessons Learned

Neil Sinclair

127. The Court also heard evidence from Mr Neil Sinclair, Chief Paramedic and Interim Director of Operations with the Northern Ireland Ambulance Service, concerning the wider context in which the events of 15 February 2022 occurred, together with the findings of the NIAS SAI review and the learning identified

following the death of the deceased. At the commencement of his oral evidence, he expressed a personal and professional apology on behalf of NIAS. He stated that the response provided to the deceased "fell below the standards we strive to achieve" and apologised for the consequences which followed for the deceased and his family.

128. The SAI review concluded that the initial 999 call received at 00.19 hours on 15 February 2022 had been incorrectly categorised as a Category 2 response and should have been categorised as a Category 1 response from the outset. Internal and external call audits identified failures to recognise ineffective breathing and reduced alertness, resulting in the call being incorrectly coded and categorised. The review and subsequent audits further identified failures to re-triage repeat calls despite reports that the deceased's condition was deteriorating.

129. The SAI review found that, had the incident been correctly categorised as a Category 1 response, existing escalation procedures would have enabled the release of ambulance crews delayed at Emergency Departments, diversion of resources from lower-acuity incidents and interruption of protected meal breaks in order to facilitate an earlier response. The review concluded that the missed opportunity to categorise the call as a Category 1 response from the outset led to a significant delay during which the deceased's condition deteriorated and that he did not receive a NIAS response that provided him with a better chance of surviving.

130. In oral evidence, Mr Sinclair confirmed the importance of accurate categorisation of emergency calls. He explained that Category 1 calls are intended to identify immediately life-threatening emergencies and carry an eight-minute target response time. He stated that a Category 1 designation permits ambulance resources to be diverted from lower-acuity calls, allows crews delayed at Emergency Departments to be released and allows protected meal breaks to be interrupted in order to facilitate the earliest possible response. He accepted that, had the deceased's initial call been categorised as a Category 1 response, those

escalation procedures would have been available. Two ambulances are released under Category 1 dispatch rules.

131. Mr Sinclair explained that the first recommendation arising from the SAI related to the recognition of ineffective breathing and reduced alertness. He stated that NIAS had subsequently developed and delivered guidance (June 2022) and enhanced training in those areas, strengthened quality assurance arrangements and introduced routine monitoring and auditing of call handling performance.

132. The SAI review further identified pressures affecting service delivery, including ambulance capacity, staffing levels and delayed hospital handovers. It concluded that delayed handovers continued to have a significant impact on the ability of the Ambulance Service to respond to patients within the community. The review noted that, whilst the deceased's call remained categorised as Category 2, there had been no earlier opportunity to allocate a resource because available crews were already committed to incidents, on protected meal breaks or delayed handing over patients at Emergency Departments.

133. Mr Sinclair confirmed that the target for the handover of patients from NIAS to Emergency Department staff remained 15 minutes. He accepted that this target had been consistently missed for a number of years and that delayed handovers remained a "significant challenge" and a "big risk" for NIAS. He agreed that prolonged handovers reduced ambulance availability and adversely affected the Ambulance Service's ability to respond to emergency calls within the community.

134. Referring to operational data from the night of the deceased's death, Mr Sinclair accepted that a number of ambulance crews were delayed outside Emergency Departments awaiting handover. He accepted that delays of up to eight hours were occurring and agreed that such delays materially affected NIAS's operational capacity. He further accepted that the inability to release ambulance crews from Emergency Departments represented a substantial operational risk.

135. Mr Sinclair accepted that prolonged delays in ambulance attendance could result in serious patient harm. He accepted the conclusions of Dr Al-Aloul regarding the likely impact of the delay in this case and confirmed that he accepted the report and its findings. He agreed that the deceased did not receive a response which provided him with the best opportunity of survival and accepted that, at the time of these events, NIAS was not capable of providing the deceased with a Category 2 ambulance response within any reasonable timeframe.

136. An extract from the Northern Ireland Audit Office report *Ambulance Handovers in Northern Ireland* (March 2025) was put to Mr Sinclair. He accepted the report's findings that Category 2 response times had significantly deteriorated since 2019 and that the longstanding eighteen-minute target had been consistently missed. He further accepted that delayed handovers had resulted in substantial losses of operational capacity and that, at the time of the deceased's death, approximately 22% of operational capacity was being lost as a consequence of delayed handovers.

137. Referring specifically to the circumstances of the deceased's case, Mr Sinclair accepted that more than three hours elapsed between the initial request for assistance and the eventual ambulance response. He agreed that this was far beyond the expected response time and stated that, in the deceased's case, "we had missed opportunities in the control room".

138. Mr Sinclair further accepted that delayed hospital handovers remained one of the most significant operational challenges facing NIAS. He accepted that the difficulties associated with ambulance handovers and response times were known both within NIAS and across the wider health service, that these issues had persisted for a number of years and that the associated risks were well recognised.

139. Mr Sinclair outlined a number of measures introduced by NIAS following the SAI review. These included enhanced training regarding ineffective breathing and reduced alertness, strengthened auditing and quality assurance processes,

updated guidance for Emergency Medical Dispatchers, expansion of Clinical Support Desk staffing, recruitment of additional operational personnel and increased clinical oversight within the Emergency Operations Centre.

140. Mr Sinclair further explained that NIAS had introduced the role of Clinical Support Manager within the Emergency Operations Centre. These clinicians now provide continuous oversight of calls awaiting ambulance allocation, undertake additional risk assessment and support Emergency Medical Dispatchers in identifying patients whose condition may be deteriorating whilst awaiting attendance. He stated that clinical supervision within the Control Room had been significantly enhanced since 2022.

141. Mr Sinclair also described ongoing work between NIAS, the Department of Health, the Strategic Planning and Performance Group and Health and Social Care Trusts aimed at addressing delayed hospital handovers and improving ambulance availability. He referred to a regional improvement programme and efforts to reduce handover delays, whilst accepting that delayed handovers continue to have a substantial impact upon ambulance response times throughout Northern Ireland.

142. Mr Sinclair stated that the recommendations arising from the SAI had either been implemented or were in the process of being implemented. He described the learning from the deceased's death as significant and stated that NIAS remained committed to improving call categorisation, clinical oversight, ambulance availability and patient safety.

Postscript

143. Lee Gannon was a much-loved son, brother and friend. The evidence of his parents painted a picture of a kind, humorous and deeply cherished young man who remained at the centre of his family's life. Ms Gannon described him as a "mummy's boy" who continued to live at home and remained exceptionally close to her. Both parents spoke movingly of the enduring impact of his death and of the profound loss felt by those who knew and loved him.

144. Following the conclusion of the hearing of this inquest, I was informed with great sadness of the death of Ms Anne Gannon. Throughout these proceedings, Ms Gannon's devotion to her son was unmistakable. She pursued the circumstances surrounding his death with determination and dignity, motivated by her love for him and her desire to understand what had happened on the night of his death. It is a matter of great sadness that she did not live to hear the delivery of these findings. I wish to record my sincere condolences to the wider Gannon family on the loss of both Lee and Anne.

145. The circumstances of the deceased's death have given rise to important learning. This inquest has highlighted the critical importance of accurate call categorisation, particularly where information is provided concerning breathing difficulties, altered responsiveness and a deteriorating clinical presentation. It has also demonstrated the importance of recognising deterioration during repeat calls and ensuring that updated clinical information is appropriately considered and acted upon.

146. I acknowledge the openness of NIAS throughout these proceedings. There was a clear acceptance of the errors identified in the categorisation and handling of the deceased's emergency calls and a commitment to learning from his death. I also acknowledge the work undertaken since 2022 in relation to dispatcher training and guidance, quality assurance and the provision of additional clinical support within the control room.

147. Sadly, this is not the first inquest in recent years in which I have heard evidence concerning delays in emergency ambulance response. The evidence before me demonstrated the significant effect which prolonged hospital handover delays can have upon the availability of ambulance resources to respond to patients in the community. Mr Sinclair's evidence, together with the Northern Ireland Audit Office material considered during this inquest, demonstrates that this remains a significant issue for the provision of timely emergency ambulance care across Northern Ireland.

148. I acknowledge the measures being taken to address these difficulties, including work by NIAS with the Department of Health, Health and Social Care Trusts and other health service partners, and measures directed towards resources, workforce capacity and alternative pathways of care. Notwithstanding those efforts, delayed hospital handovers remain an important patient safety issue.

149. I have addressed in my findings above the significance of the individual failures and wider operational pressures disclosed by the evidence in this case. I recognise the learning which has been identified and the changes which have followed the deceased's death. It is important that the effectiveness of those measures continues to be kept under review.

150. I conclude by expressing my sincere condolences to the Gannon family for the losses they have suffered. I also wish to thank them for the dignity and patience they have demonstrated throughout the inquest process. It is my hope that the findings of this inquest, and the learning arising from the deceased's death, will contribute to improvements in patient safety and reduce the risk of similar circumstances arising in the future.