ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive Officer South East Coast Ambulance Service NHS Foundation Trust**
1	**CORONER** I am Sonia Hayes assistant coroner, for the coroner area of Mid Kent & Medway
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 22 June 2021 an investigation was commenced into the death of STEVE MARTIN BRIAN COOKE. The investigation concluded at the end of the inquest on 23 July 2021. The conclusion of the inquest was COVID-19 Pneumonia due to COVID-19 Infection - Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Steven Cooke was found deceased at home on 26th December 2020 by police doing a welfare check due to family concerns of COVID19 Pneumonitis due to COVID-19 infection with a positive test on 23rd December 2020. Steven called an ambulance with extreme shortness of breath and apparent hypoxia on 25th December 2020 and an ambulance was dispatched as a category 2 within 26 minutes. There were communication difficulties, and the ambulance crew was dispatched to the wrong address and Steven was not located.

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. Evidence was heard at the Inquest that there were communication difficulties that resulted in the ambulance being dispatched to the wrong address and Mr Cooke not being located: Mr Cooke made an emergency call taken by NHS 111 with symptoms of COVID-19 and was extremely breathless with apparent hypoxia, the call handler was struggling to understand him in a busy working environment. The call was transferred for clinical assessment and an ambulance was dispatched. Paramedic ambulance crew arrived in under five minutes to an address provided by the emergency operations control (EOC) and could not locate the patient, Mr Cooke. The crew checked the address with EOC and managed to gain access from a key holder to the address that was unoccupied and a thorough search and enquiries with neighbours established the address was unoccupied. The **MATTERS OF CONCERN** are as follows. – (1) Ambulance crew updated EOC Mr Cooke could not be located. EOC made checks with a telephone number on the system to attempt to establish the location of Mr Cooke. This telephone number was Mr Cooke's ex-partner on 25th December 2020.The EOC established that Mr Cooke was not with his ex-partner. The call handler when speaking to Mr Cooke's ex-partner: (i) EOC terminated the call within 62 seconds – this very brief given the serious nature of the query to locate a missing sick patient (ii) did not give a complete explanation of the reason for the call (iii) did not ask for Mr Cooke's current address (iv) instead suggested part of the address that the crew had been dispatched to knowing Mr Cooke could not be located there and did not listen to or give sufficient time for Mr Cooke's ex-partner to respond (v) did not update Mr Cooke's ex-partner that Mr Cooke had not be located (2) Mr Cooke was very unwell and in need of medical attention: (i) the matter was not escalated further when Mr Cooke could still not be located (ii) the original call was not listened to again to attempt to establish the correct address being given by Mr Cooke. Mr Cooke gave the address as [redacted] Hammond Hill and it was the call handler who suggested a different part of the address as there was difficulty establishing the postcode and this was approximately five metres from where Mr Cooke lived. (iii) It was possible to hear Mr Cooke stating with difficulty the word 'opposite' when this part of the address was suggested.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 5th October 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 Persons [redacted] [redacted] (ex-partner). I have also sent it to CQC who may find it useful or of interest. I am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	Signature: S. M. Hayes Sonia Hayes Assistant Coroner **Mid Kent and Medway** 8th August 2021