	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] - CEO Birmingham Integrated Care Board • [redacted] - Regional Medical Director NHS England • The Rt Hon Sajid Javid MP - Secretary of State for Health and Social Care
1	**CORONER** I am Miss Emma Brown, HM Area Coroner for Birmingham and Solihull
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 18 October 2021 I commenced an investigation into the death of Lee Anthony CARUANA. The investigation concluded at the end of the inquest on 14 June 2022. The conclusion of the inquest was a narrative conclusion as follows; *Death was due to natural causes contributed to by a delay in ambulance attendance.*
4	**CIRCUMSTANCES OF THE DEATH** The Deceased died at 05:38 on the 6 October 2021 at the Queen Elizabeth Hospital, Birmingham. He had been suffering from COVID19 for 8 days and on the 5 October 2021 a 999 call was made at 14:44 after family identified his lips and hands were blue. Further calls, some to 111, were made during the afternoon and evening. There were omissions in the handling of the calls meaning that it was not identified that an ambulance was required until a call at 23:53. Due to pressures on the Ambulance Service an ambulance was not available until 02:42. When the ambulance arrived with Mr Caruana at 03:10 he was extremely ill and struggling to breathe. He was transported to the Queen Elizabeth Hospital but despite treatment went into cardiac arrest and could not be resuscitated. The delay in medical treatment contributed to his death. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Covid-19** **1b** **1c** **II Obesity**
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. During the inquest, evidence was given on behalf of West Midlands Ambulance Service from Clinical Governance Lead [redacted] and Trust Investigations Officer [redacted] that at the time of Mr Caruana's death the Trust was experiencing

	unprecedented demand due to high call volume and delays in handing over patients to hospitals. At the time Mr Caruana was identified as needing an ambulance following a 999 call at 23:53 on the 6 October 2021, 71 of the Trusts 253 ambulance crews on duty were at hospital awaiting handover, the longest wait that day had been 7 hours and 45 minutes for a crew waiting at Birmingham Heartlands Hospital. 2. Since October 2021 the number of calls received has started to reduce to normal levels. However, the problem of paramedic crews being stuck at hospitals awaiting handover has increased. As an Investigations Officer [redacted] said she is continuing to see incidents where ambulance attendance has been delayed because a crew was not available due to the number of crews waiting at hospital. Her evidence was that this is putting lives at risk. 3. [redacted], Governance and Performance Manager at London Ambulance Service, gave evidence to the inquest as an independent expert. In the course of his evidence, he explained that the problem of ambulances being stuck awaiting handover is a national issue. Based on his anecdotal experience and observations the number of calls that a crew is able to attend to in a 12 hour shift has dropped by approximately 1/3 as a result of this issue. 4. The evidence from West Midlands Ambulance Service is that they have raised awareness of this issue locally, they have taken steps to free up ambulances (such as leaving multiple patients under the care of one paramedic crew at hospital to free up other crews to leave and diverting patients to other services where possible) and there is nothing further that they can do. 5. In the circumstances it is my conclusion that the availability of ambulance crews is being compromised by delays at hospitals resulting in delays in response times which creates a risk to the life.
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 11 August 2022. 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], West Midlands Ambulance Service. I have also sent it to the Birmingham and Solihull CCG and the CQC, 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 June 2022** Signature:  **Miss Emma Brown** **HM Area Coroner for Birmingham and Solihull**