HSE

Health and Safety Executive

Katy Thorne KC
Assistant Coroner
Berkshire Area

By email: [redacted]

Engagement and Policy Division
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[redacted]

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Date 12 January 2023

Dear Katy Thorne KC,

Re: Prevention of future deaths report - Levi Louis Alleyne

Thank you for your Regulation 28 report to prevent future deaths issued following the inquest into the death of Levi Louis Alleyne.

In this report, you highlighted that the potential for future deaths was two-fold:

1. Unnecessary delay to life-saving treatment being given due to the fear that overhead power lines (OHPL) are still live, and
2. Potentially by-standers or emergency services putting their lives at risk by approaching patients near electrical hazards where OHPLs remain live.

In relation to the first concern, in England the Care Quality Commission (CQC) is the lead inspection and enforcement body for safety and quality of treatment and care matters involving patients and service users in receipt of a health or adult social care service from a provider registered with CQC. The Memorandum of Understanding between CQC and HSE explains the respective roles and responsibilities of each organisation with regard to health and safety incidents.

This means that delays to life-saving treatment for patients provided by the ambulance service in England would fall within the remit of CQC and not HSE. We have therefore shared this report with CQC to consider.

In Wales, the Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare. HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to check that patients, the public, and others are receiving safe and effective care which meets recognised standards. The Memorandum of Understanding between HIW and HSE sets out our roles and responsibilities in further detail. As this would fall within HIW's remit, we have shared this report with them.

In relation to the second concern, the Association of Ambulance Chief Executives (AACE) have advised that actions taken by South Central Ambulance Service NHS Trust following the inquest, including to update their Standard Operating Procedures (SOPs), have been shared across all NHS ambulance services. This includes a map and the appropriate contact details for each of the Distribution Network Operators (DNOs). This matter is due to be discussed further with all Heads of Emergency Operations Centres at their meeting in January 2023.

HSE has also shared these concerns with the Association of Police Health and Safety Advisors (APHSA), the National Police Chiefs Council (NPCC) and the National Fire Chiefs Council Health and Safety Committee to ensure all emergency services are aware and check they have suitable procedures in place to deal with incidents involving equipment on the electricity network.

We have contacted the Energy Networks Association (ENA), who have advised that DNOs and Transmission Network Operators (TNO) have suitable and effective arrangements in place with their local emergency services providers. This includes ensuring that emergency services have suitable emergency contact details for their DNO and that they know how to respond to an incident involving equipment on the electricity network. In future, the ENA has requested that DNOs and TNOs check their arrangements with the emergency services on an annual basis.

The ENA are currently reviewing their information leaflet on *Safety Advice for the Emergency Services*. HSE has commented on the draft document and the review is due to be completed by the end of January 2023.

I hope this clarifies the situation but please let me know if you need anything further.

Yours sincerely

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Head of Transportation and Public Services Unit