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. Energy Networks Association** **2. Ofgem** **3. Association of Ambulance Chief Executives** **4. NHS Digital** **5. Health and Safety Executive**
1	**CORONER** I am Katy Thorne KC assistant coroner, for the coroner area of Berkshire.
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 23 November 2020, I commenced an investigation into the death of Levi Louis Alleyne age 41. The investigation concluded at the end of the inquest on 3rd October 2022. The conclusion of the inquest was accident. The medical cause of death was electrocution.
4	**CIRCUMSTANCES OF THE DEATH** 1. Levi Louis Alleyne died on 16th November 2020 at Bartletts Farm by electrocution while pursuing his occupation as a grab lorry delivery driver. 2. He had been hired to deliver material to a building site where Overhead Power Lines were sited. No warnings, verbal or visual, were provided to him about the presence of the Overhead Power Lines [OHPLs]. He reversed his lorry onto the site and raised the crane arm of his grab lorry directly under the OHPLs. The electricity arced onto the crane arm, through the lorry and into Mr Alleyne. 3. Scottish and Southern Electricity Networks [SSEN] were the local Distribution Network Operator [DNO]. An automatic protection system on the OHPLs operated within a few seconds to isolate the relevant section of the overhead power line, which cut off the power to one of the lines. 4. A bystander rang 999 at 1133 hours and expressed his reluctance to approach Mr Alleyne due to the risk of electrocution. The South Central Ambulance Service [SCAS] operator, who did not know whether the power lines were still live or not, advised him not to approach. For this reason, no CPR was administered until the Air Ambulance arrived. 5. Although there had been no confirmation that the electricity was now safe, Air Ambulance personnel picked up Mr Alleyne and administered CPR from 1152,

	but despite their efforts, Mr Alleyne died at the scene. 6. After calling 999, at 1146 hours, the bystander contacted Scottish and Southern Electricity [SSEN] who shut off the electricity to all three of the power lines. 7. At 1150, the SCAS operator attempted to contact SSEN but did not get through for 9 minutes. 8. At 1202 SSEN confirmed to SCAS that the power was off.
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. The **MATTERS OF CONCERN** are as follows. – According to the evidence heard at the inquest: 1. At the time of the incident, the SCAS operator did not have any instruction in their Standard Operating Procedure to contact the local [DNO] to ensure that the electricity was cut off. There is no such instruction in the national Standard Operating Procedure. 2. The SCAS operator did identify and try to contact the DNO after the 999 call had ended. However, as they did not contact the correct emergency number provided by SSEN, they were kept on hold for several minutes. The emergency numbers are not incorporated into the software used by the ambulance control centre (CAD) and are not widely known. 3. There is considerable potential for confusion for ambulance control centres as there is not one national DNO emergency number to contact. There are 14 licensed DNOs and 12 ambulance service trusts in England and Wales with different boundaries. Ambulance control centres frequently pick up calls from other ambulance trust areas at times of high demand. The ambulance control centre must find the relevant DNO to contact and the relevant number for that DNO. 4. There was a delay in Mr Alleyne receiving CPR due to concerns about electricity still being live. There are thousands of incidents every day involving OHPLs. There is a risk that future deaths may occur due to confusion regarding electrical hazards. 5. The potential for future deaths is two-fold: ▪ unnecessary delay to life-saving treatment being given due to the fear (well-founded or otherwise) that OHPLs are still live, ▪ or potentially, by-standers or emergency services putting their lives at risk by approaching patients near electrical hazards where OHPLs remain live. As a result of the inquest, SSEN and SCAS introduced new procedures to ensure the electrical risk is reduced in the shortest time possible whilst taking into account the time and resource pressure on SCAS when dealing with emergency situations. 1) SSEN has provided SCAS with a map of England and Wales containing direct emergency numbers for each DNO and which areas it covers. 2) SCAS has changed its Standard Operating Procedure to include an instruction for an operator, during a 999 call, to ask a nearby operative to contact the DNO

	if scene safety is compromised due to electrical hazards. 3) SCAS Critical Systems Manager has created a process within CAD that, when clicked, will launch the website and map provided by SSEN. However, there is no guarantee that a similar procedure or other mitigating measures will be adopted across England and Wales and so there remains a risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 30 December 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: the family of Mr Alleyne, and the relevant landowners and contracting parties, [BBM Contracts Ltd, [redacted] I have also sent it to SSEN and SCAS 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	**[DATE]** **[SIGNED BY CORONER]** **4 November 2022**