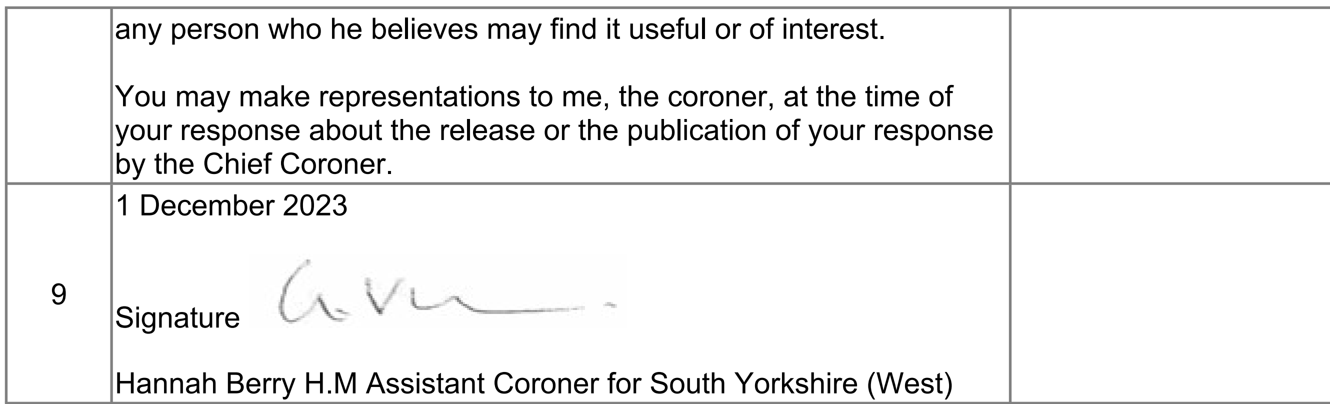
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU** **2. The South Yorkshire Integrated Care Board, 722 Prince of Wales Road, Sheffield, S9 4EU**	
1	**CORONER** I am Hannah Berry, Assistant Coroner for South Yorkshire (West).	
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 20 June 2023 I commenced an investigation into the death of David John BRIGGS. The investigation concluded at the end of the inquest on 30 November 2023. The conclusion of the inquest was that Mr David Briggs, died on 15 November 2022 at the Northern General Hospital, Sheffield from an infection resulting from catheterisation. The medical cause of death was: 1a. Urosepsis 1b. Urinary tract obstruction 1c. Spina bifida	
4	Mr Briggs had spina bifida with paralysis from the waist downwards and resided in supported living where he relied heavily on support staff for everyday living. He had a long term supra pubic catheter and colostomy and in early November 22 Mr Briggs's carers became concerned that his catheter wasn't draining properly and with engagement with primary care Mr Briggs was prescribed antibiotics for a possible urinary tract infection on 12 November 2023. At 2049 on 14 November Mr Briggs's carers called 999 as he was struggling to breath. The call was routed to Yorkshire Ambulance Service (YAS) who coded the call as a Category 2 (expected response within 40 minutes). At 2145 a second 999 call was made which was answered by East Midlands Ambulance Service (EMAS) having been routed by BT. This call was also coded as a Category 2 and passed to YAS. At 2219 a third 999 call was made and answered by YAS as Mr Briggs's breathing was worse and he was struggling to breath in-	

	between talking. This call was again coded as a Category 2 At 2339 a fourth 999 call was made which was again answered by EMAS. This call was incorrectly coded as a Category 2 by EMAS, instead of a Category 1 and passed to YAS. At 0027 the final 999 call was made. Mr Briggs was unresponsive and not breathing. The call was coded as a Category 1 and carers advised to start CPR. The YAS ambulance arrived at 0044 and after initial treatment David was transferred to the Northern General Hospital in Sheffield where he was pronounced dead at 0231.	
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) The ambulance service was called at 2049 on 14 November 2022 and the call was graded as a Category 2 call requiring a response within 40 minutes. The ambulance finally arrived at 0044 on 15 November 2022. (2) YAS were not resourced to respond to the number of emergency calls. (3) There was a significant delay in offloading patients at hospitals which tied up ambulance resource and meant they were unable to respond to emergency calls.	
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 25 January 2024. 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; - Mr Briggs's family - Yorkshire Ambulance Service, Brindley Way Wakefield 41 Business Park Wakefield WF2 0XQ - East Midland Ambulance Service, 1 Horizon Place, Mellors Way Nottingham Business Park Nottingham, NG8 6PY I may also send a copy of your response to any 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 by the Chief Coroner.	
9	1 December 2023 Signature Hannah Berry H.M Assistant Coroner for South Yorkshire (West)	