	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 West Yorkshire Integrated Care Board, White Rose House, West Parade, Wakefield, WF1 1LT
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 19 December 2023 I commenced an investigation into the death of Jean WALKER. The investigation concluded at the end of the inquest on 20 March 2024. The conclusion of the inquest was that; Mrs Jean Walker died on 4 November 2022 having collapsed struggling to breathe at her home address [redacted] Sheffield. An ambulance was called but delays to its arrival resulted in a missed opportunity to give medical assistance. It cannot be said that if she had received earlier intervention that her death would have been prevented. 1a Pulmonary Emboli 1b Deep vein thrombosis 1c II
4	**CIRCUMSTANCES OF THE DEATH** On 4 November 2022 Mrs Walker called her daughter as she was feeling unwell. Her daughter attended her at her home address and at 0348 called 999 as she was struggling to breathe. The call was correctly coded as a Category 2 (expected response time of 40 minutes) and Mrs Walker's daughter was told an ambulance would be with her within 40 minutes. An ambulance was dispatched at 0526, arriving at 0542. At some point between the 999 call at 0348 and the ambulance arrival at 0542 Mrs Walker died. She was pronounced dead at 0551 by the attending paramedic.

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 0348 on 4 November 2022 and the call was coded as a Category 2 call requiring a response within 40 minutes. The ambulance finally arrived at 0542 on 4 November 2022, 1 hour and 56 minutes after the call. (2) 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 you r 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 16 May 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; 1. Mrs Walker's family 2. Yorkshire Ambulance Service, Brindley Way, Wakefield, WF2 0XQ 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	20 March 2024 Signature  Hannah Berry H.M Assistant Coroner for South Yorkshire (West)