**M. E. Voisin**
**Her Majesty's Senior Coroner**
**Area of Avon**

15th March 2024 [redacted]

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: South Western Ambulance Service Trust** |
| 1 | **CORONER**<br><br>I am **Dr Simon Fox KC** Assistant Coroner for **Area of Avon** |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>I held an Inquest in the death of **Romeo Miles Esposito** on 14-15th March 2024. The conclusion of the inquest was –<br><br>Romeo was found unconscious in bed at home. Emergency staff attended but stopped resuscitation and assessed Romeo as having died. This proved incorrect – he continued to make respiratory effort and his heart beat returned for some time before resuscitation resumed. However, he died in hospital the next day from a brain injury consequent upon his cardiac arrest. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>See below. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) Romeo was making respiratory effort for about an hour after ROLE at 0952 hours and resuscitation being resumed at 1049 hours;<br>(2) His family raised their concerns regarding this with SWAS clinical stff on a number of occasions thoughout this period;<br>(3) Staff repeatedly ascribed the respiratory effort to *"a release of air"*, as opposed to a change in Romeo's clinical condition which required further clinical assessment; |

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| | (4) There was no evidence to confirm that clinical staff have been warned or trained not to use *"a release of air"* as an explanation for respiratory effort or a reason to avoid further clinical assessment. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the chief coroner and to the family.<br><br>I am also under a duty to send the chief coroner a copy of your response.<br><br>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 | <br><br>**Dr Simon Fox KC** Assistant Coroner **Area of Avon** |