REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) The Right Honourable Steve Barclay MP** **Secretary of State for Health and Social Care** **2) [The East of England Ambulance Service NHS Trust]**
1	**CORONER** I am Peter Taheri, Assistant Coroner, for the coroner area of Suffolk.
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 15th October 2021 an investigation was commenced into the death of Michael James Francis Bray. The investigation concluded at the end of the inquest on 16th February 2023. The Jury's narrative conclusion of the inquest was that: **Michael Bray died by way of misadventure.** **Points that possibly contributed to Michael's death include:** **• The Fast Action Response Plan, and whether it should have been updated to include risks arising from the near-miss on 23 September 2021 and PC Cook's view by 4th October 2021 that the risks of suicide / misadventure had risen to high.** **• Whether the Police should have deployed resources upon learning, at about 2.02am on 10th October 2021, that Michael was no longer on the telephone to the mental health professionals together with the knowledge that an ambulance could take up to 120 minutes to arrive.** **• Whether the Ambulance Service should have asked Police to deploy a resource because of delays in sourcing an available ambulance.** **• The Ambulance Service omission to bring the Police declining to attend, at about 3.18am, to the attention of the Ambulance dispatcher, leading to a one-hour delay in the dispatcher becoming aware that Police would not attend.** **• The appropriateness of the ambulance crew's dynamic risk assessment on arrival at Michael's home address and their decision not to approach his house and check his door and check welfare.** **• The period of time taken for the ambulance crew to chase for the whereabouts of Police attendance.** **• The timing of any escalation of the Ambulance Service request for Police attendance.**

	• **Shortcomings in software and communication systems, amongst agencies** • **Poor interpretation, misunderstanding and poor analysis of the information available to agencies concerned. The sharing and agreement of actions, at times lacked urgency.** • **The police failing to complete a welfare check after an initial call from the Crisis Team.** The medical cause of death was confirmed as: **1(a) Hanging**
4	**CIRCUMSTANCES OF THE DEATH** The Jury's answer to how, when, where and in what circumstances the deceased came by his death was: **Michael Bray was at home on 9th and 10th October 2021** **He had been drinking alcohol and called the Crisis Helpline stating [redacted] considering hanging himself. After the call, he proceeded, resulting in his death sometime between 1:55-5:53, 10th October 2021** After the conclusion of the evidence, I ruled that on the evidence the Jury could not safely make any finding of fact on the balance of probabilities on the precise time of death other than that death occurred between about 1.50am and 5.53am on 10th October 2021. The Jury were directed to, and did, answer the question of when the deceased died accordingly. A notable feature of this case was a lack of availability or provision of an ambulance to respond in a timely manner to the deceased's Category 2 call, which contributed to a considerable delay. On the evidence, the national ambulance target response time for a Category 2 call is an average of 18 minutes, with 90% of calls to be responded to within 40 minutes. In this case, the ambulance response took a period of time in the hours, considerably greater than the target response time.
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: – Although it could not be safely said when the deceased died, and therefore it could not safely be said that the delay in the ambulance response probably contributed to the death, the concern is that long delays in ambulance response to Category 2 calls create a risk that other deaths will occur in the future. Bearing in mind the national ambulance target response time for a Category 2 call of an average of 18 minutes, with 90% of calls to be responded to within 40 minutes: The average Category 2 response time for the East of England Ambulance Service NHS Trust ('EEAST') in October 2021, the month of this death, was 56 minutes and 2 seconds.

	The same average time for January 2023, the most recent month for which data was available, was 49 minutes and 3 seconds. Every month since the deceased's death, EEAST's Category 2 response time has been above the 90th centile time of 40 minutes. The average EEAST Category 2 response time for a given month in the period from October 2021 to January 2023 is over 1 hour, with a standard deviation of about 20 minutes. Therefore, EEAST's Category 2 response time remains persistently and consistently far off target. Although I accept on the evidence that action is being taken, on both local and national levels, to prevent future deaths as a result of this issue, the evidence of the results of such actions to date is that these actions have been demonstrably ineffective and have not resulted in a Category 2 average response time for EEAST that is even close to the target time. The evidence received was that this issue, and the causes for it and the action required, are not just local in nature, but also national.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe each of you and / or your organisations 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 17th July 2023. 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 Bray Family (in particular [redacted], the deceased's son, and [redacted], the deceased's wife) - [redacted] - The Chief Constable of Suffolk Constabulary - Norfolk & Suffolk NHS Foundation Trust I am 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	**22nd May 2023** **Peter Taheri**