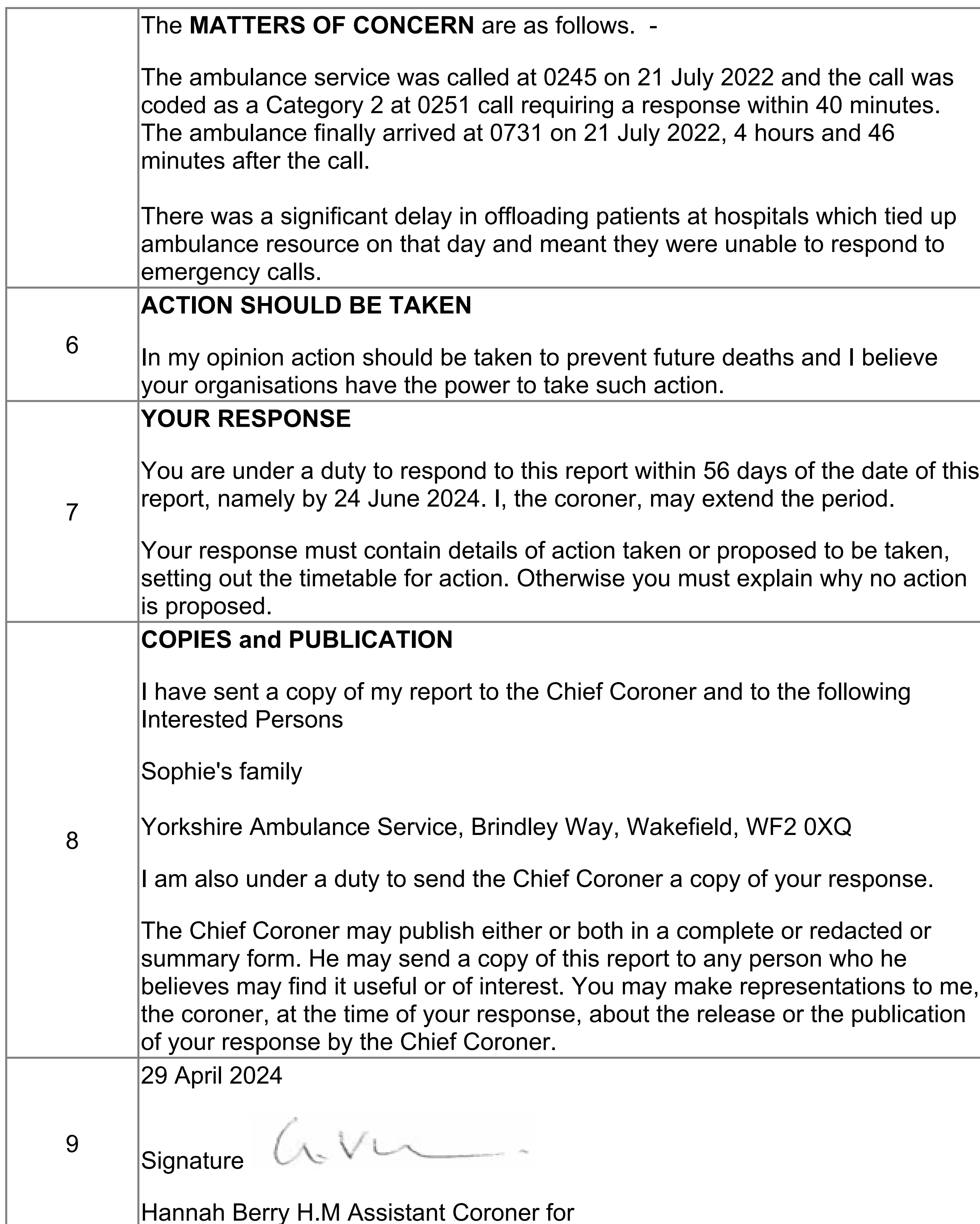
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU** **NHS England, PO Box 16738, Redditch, B97 9PT** **The West Yorkshire Integrated Care Board, White Rose House, West Parade, Wakefield, WF1 1LT**
1	**CORONER** I am Hannah Berry, Assistant Coroner for the Coroner area of 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 18 September 2023 I commenced an investigation into the death of Sophie HINDMARSH. The investigation concluded at the end of the inquest on 29 April 2024. The conclusion of the inquest was of n atural causes.
4	**CIRCUMSTANCES OF THE DEATH** Sophie had complex needs and required full time care. At 0245 on 21 July 2022 Sophie's father called 999 as she was vomiting brown liquid, felt hot to touch and her percutaneous endoscopic gastronomy feeding tube was leaking. The call was initially coded as a Category 1, but at 0251 was correctly recoded as a Category 2 by the Senior Clinical Advisor. An ambulance was dispatched at 0716, arriving at 0731. Within that 24 hour period 156 ambulance hours were lost to delays handing over patients to hospitals. Sophie was conveyed to Northern General Hospital in Sheffield where she sadly died on 17 August 2024.
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. - The ambulance service was called at 0245 on 21 July 2022 and the call was coded as a Category 2 at 0251 call requiring a response within 40 minutes. The ambulance finally arrived at 0731 on 21 July 2022, 4 hours and 46 minutes after the call. There was a significant delay in offloading patients at hospitals which tied up ambulance resource on that day 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 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 24 June 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 Sophie's family 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	29 April 2024 Signature Hannah Berry H.M Assistant Coroner for