	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **1. NHS England** **2. West Yorkshire Integrated Care Board**
1	**CORONER** I am Jessica Swift, Assistant Coroner for the City of Kingston Upon Hull and the East Riding of Yorkshire.
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 6 January 2023 an inquest was opened into the death of Josh Andrew Smith, aged 30 years. The inquest concluded on 4 July 2024 by way of a **narrative conclusion**, worded as follows: ***On a background of longstanding medical complications arising out of quadriplegia sustained in a historic road traffic incident, Josh Andrew Smith died of hypoxic brain injury secondary to an out of hospital cardiac arrest which was caused by underlying natural disease processes.***
4	**CIRCUMSTANCES OF THE DEATH** Mr Smith had a long-standing history of medical complications, consequent to quadriplegia which arose following injuries he sustained in a road traffic incident in 2009. On 16 December 2022, Mr Smith spoke with a General Practitioner over the telephone and was prescribed antibiotics for a chest infection. On 19 December 2022 at approximately 05:49 hours, an ambulance was called for Mr Smith as he had been found unresponsive and was not breathing. The 999 call was placed within a queue and was answered by the ambulance service at 06:05 hours. The ambulance service triaged this call and a Category 1 response was achieved. An ambulance arrived with Mr Smith at 06:21 hours, Mr Smith was conveyed by ambulance to Hull Royal Infirmary where it was identified that he had suffered a hypoxic brain injury. CT scans also demonstrated evidence of bronchopneumonia and Mr Smith al tested positive for influenza A. Despite maximal treatment, Mr Smith's condition did not improve and he was placed on palliative care. Mr Smith died on the 22 December 2022.

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:– I heard evidenced that whilst the Yorkshire Ambulance Service have taken a number of steps within their powers to try to reduce the delays experienced by patients waiting for an ambulance within the community, that those delays continue. Specifically, I was told that the response standards for both Category 1 and Category 2 calls (for the year to date), whilst improved from the time of Mr Smith's death, still remain outside of the target response standards (both on average and at the 90th centile). The evidence heard was that the national target for hospital handover by the ambulance service, of 15 minutes, is still not being achieved. Evidence suggested that whilst there has and continues to be efforts made by the ambulance service and acute hospitals to increase the speed at which ambulances handover their patients, that delays in this process continue to impact upon the speed of the ambulance response to patients waiting within the community.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 **9 September 2024**. I, the Coroner, may extend this 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 Smith's family ▪ Yorkshire Ambulance Service NHS Trust ▪ Humber Teaching NHS Foundation Trust I have also sent it to the following who may find it useful or of interest: ▪ Association of Ambulance Chief Executives (AACE) 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. She may send a copy of this report to any person who she 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. Your response will also be shared with the above named Interested Persons.

9	**Jessica Swift** **Assistant Coroner for the City of Kingston Upon Hull and the East Riding of Yorkshire** **15 July 2024**