REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Secretary of State for Health and Social Care** **2. NHS ENGLAND**
1	**CORONER** I am Hannah Godfrey Area Coroner for the coroner area of Berkshire
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. A prevention of future deaths report raises issues and is a recommendation that action should be taken but does not recommend what that action should be. That is a matter for the recipient. It is important to note the case of *R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London*. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION and INQUEST** On 23 May 2024 I opened an inquest into the death of Mrs Susan Dear on 4 January 2023 aged 72. The inquest concluded on 9 September 2024. The family requested that I refer to Mrs Dear as Susan, which this report will reflect. The conclusion of the inquest was that Susan had died of natural causes (Pulmonary Embolism due to underlying Deep Vein Thrombosis).
4	**CIRCUMSTANCES OF THE DEATH** Susan was suffering abdominal pain, and her family called 999 at 10.20 pm on 3 January and that call was triaged at category 3 (meaning that an ambulance was expected to be on scene within 120 minutes). At that time the inquest heard that there were 48 patients awaiting ambulances, 7 were waiting for category 2 ambulances with the longest wait time being 1 hour 12 minutes, 19 patients were waiting for category 3 ambulances with the longest wait time being 7 hour 55 minutes. Susan's symptoms deteriorated and a second 999 call made at 2.32 on 4 January was triaged at category 2 (meaning that an ambulance was expected to be on scene within

	40 minutes). At that time the area was in OPEL 4, the highest OPEL level, indicating Extreme Pressure on resources. There were 37 patients waiting for ambulances. 9 patients were awaiting category 2 ambulances with the longest wait being 5 hours 53 minutes, and 26 patients were awaiting Category 3 ambulances, with the longest waiting time being 14 hours 39 minutes. There was no ambulance resource available to respond at any time to Susan. At around 5 am Susan's family decided they could wait no longer and drove her to hospital, where she was recognised as deceased shortly after arrival at 6.02 am. On the evidence at inquest I did not find that the ambulance delay contributed to Susan's death.
5	CORONER'S CONCERNS During the course of the investigation and 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: (1) South Central Ambulance Service ('SCAS')'s internal investigation established that there had been no missed opportunity to send an ambulance during the time that Susan was waiting overnight on 3 to 4 January 2023 as none was available; and (2) overnight between 3-4 January 2023 patient's lives were put at risk because SCAS did not have ambulances available to meet the level of demand resulting in severe delay and ambulance response times far outside the national expected standards; and (3) this was not unprecedented but was reflective of a picture of a chronic situation whereby there was a continuing risk that demand for emergency ambulances would outstrip resources and SCAS were unable to reassure me this was a situation that had been resolved; and (4) SCAS have an SCAS wide improvement programme which is aimed at increasing capacity, which is monitored by NHS England and the Trust's own commissioners. There was no evidence indicating anything that it was within SCAS's power to change on this occasion; and (5) SCAS's service was operating at under the number of planned staff for that night, (despite the service taking all reasonable steps to meet requirements) due to chronic understaffing of the service with recruitment and retention issues with paramedic and other emergency response staff that the inquest heard are problems nationally; and (6) handover delays at the Royal Berkshire Hospital and the Wexham Park Hospital were found to be a substantial root cause of the problem (due to ambulance staff being delayed at hospital with patients who could not be admitted to Accident & Emergency as other patients were unable to be admitted to the wards until beds were available) and that this was a problem that required improvement at a national level with changes to the social care system to ease the discharge of patients who required care in the community from the wards back into the community; and (7) resources were being wasted due to ignorance of some of members of the

	public engaging with the service, and the inquest heard that it was unlikely this would improve substantially without a programme of public education regarding when it is appropriate to call 999, and when it is not.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation 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 14 November 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. [redacted] (Susan's husband), 2. South Central Ambulance Service and 3. The Finchampstead Surgery. I have also sent it to The CQC and The Association of Ambulance Chief Executives who may find it useful or of interest. 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 September 2024**  **Hannah GODFREY** **Area Coroner for Berkshire**