Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Secretary of State for Health and Social Care.** **2 Chief Executive, NHS England.**
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire for the coroner area of Berkshire The family asked me to refer to the deceased as Andrew. This report reflects that request.
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. 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** On 22nd of May 2024 I opened an inquest into the death of Andrew Michael Lewis. The inquest was conducted on 6th of December 2024. The cause of death was: 1a) Acute on Chronic Gastrointestinal Haemorrhage 1b) Bleeding Oesophageal Varices 1c) Alcoholic Liver Cirrhosis 2) Low volume Subdural Haemorrhage The conclusion of the inquest was:

	Alcohol-related, contributed to by head injury.
4	**CIRCUMSTANCES OF THE DEATH** Andrew Lewis was a 55 year old man who died at home on the 7th of May 2024. He called 111 at 13:42 on 7th of May 2024, reporting weakness in his legs and an earlier fall. The key times are: 13:42 — Called 111, categorised as Category 3 (ie response time within 120 minutes for 90% of calls). This decision required confirmation by a clinician within South Central Ambulance Service ('SCAS'), as the original call was to 111. 15:17 — SCAS categorised the call as Category 3. The 120 minute 'clock' began to run at this point. An ambulance should therefore have been in attendance by 17:17. 23:45 — Ambulance arrived. Andrew was deceased. This ambulance arrived because family and police had attended the property, broken in and found him unresponsive – the call was then categorised as Category 1 (the most urgent category). I accepted at inquest that the reason for this chronology was that there was simply no ambulance to send earlier.
5	**CORONER'S CONCERNS** During the course of the investigation my enquiries 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:

Facts of this case

An ambulance resource arrived around 10 hours from Andrew's first call (to 111 services), and 8 ½ hours after the ambulance service categorised this as a call requiring attendance within 2 hours.

South Central Ambulance Service generally

The NHS has a framework called OPEL (Operational Pressures Escalation Level), designed to manage capacity at times of excess demand. SCAS' version of this is called REAP (Resource Escalation Action Plan).

The levels are:

REAP level 1 – Steady state.
REAP level 2 – Moderate pressure.
REAP level 3 – Major pressure.
REAP level 4 – Extreme pressure.

There are also categories for critical incidents and major incidents.

I obtained information from South Central Ambulance Service about their escalation levels in the last 2 years. The specific data can be provided, but the headlines (for the period 3rd of August 2022 to 9th of October 2024) are:

- **SCAS has been at REAP 3 or above for 90% of this time period. They have been constantly at REAP 4 since 9 October 2024.**

- The lowest escalation level that this ambulance service has been at in this period is REAP 2. They have never been at steady state (REAP 1) during this period.

- I have also been provided with data regarding the number of hours that ambulances have spent queuing at hospitals in the last 3 months (September to November 2024). This amounts to 23,253 hours. **This is an average of 255.5 hours across the service every single day**.

The national picture

1. In the period July 2013 to 24th November 2024, 217 Prevention of Future Deaths Reports ('PFDs') were written to ambulance trusts. It is fair to say that

	not all of these will relate to delay, but a significant number of them do. 2. There appears to be no oversight of this issue, and a number of ambulance trusts have not responded to these reports at all. 3. I have attached an article published by the Preventable Deaths Tracker in November 2024, which provides further information regarding ambulance PFD reports.
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 February 13th, 2025. 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 or organisations who may find it useful or of interest: 1. Andrew's family. 2. South Central Ambulance Service NHS Foundation Trust. 3. Association of Ambulance Service Chief Executives. For the avoidance of doubt, a response is only requested from the two recipients referred to at the top of this report. I am also under a duty to send the Chief Coroner a copy of your responses. 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	**Dated: 19/12/2024**

	 **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**