	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: South Western Ambulance Service NHS Foundation Trust**
1	**CORONER** I am Vanessa McKinlay, Assistant Coroner for Somerset
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 24 June 2024 I commenced an investigation into the death of Graham Whiteley. The investigation concluded at the end of the inquest on 29 January 2025. The conclusion of the inquest was: Accident.
4	**CIRCUMSTANCES OF THE DEATH** Mr Whiteley suffered from Alzheimer's disease with a history of seizures and falls. He lived in a care home. On 9 June 2024, Mr Whiteley walked out of the care home alone when the doors were inadvertently and momentarily left unlocked. He was found by a member of the public having fallen at the side of the road and sustained head injuries. Owing to severe pressure on the ambulance service, an ambulance was not dispatched until a decision had already been made for the police to convey Mr Whiteley to Musgrove Park Hospital. On admission to hospital he was diagnosed to have sustained facial fractures and an intracranial bleed. Neurosurgery was not indicated owing to Mr Whiteley's frail condition and co-morbidities. He developed pneumonia and he died in hospital on 18 June 2024. [redacted] (Consultant Trauma and Orthopaedic Surgeon) gave the medical cause of death as: 1a Hospital acquired pneumonia 1b Polytrauma secondary to fall 1c Advanced dementia
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:

	a) The 999 call to the ambulance service was received at 14.24 hours. The Emergency Medical Dispatcher was informed that Mr Whiteley had fallen, had banged his head, was bleeding and was barely conscious. This generated a category 2 response requirement. b) At 15.03 hours there were 107 incidents awaiting allocation across the ambulance Trust area, including 21 in the Bravo patch where Mr Whiteley's incident occurred. c) The excessive number of incidents awaiting allocation was caused by delays in handing over the care of patients from ambulance crews to the four main acute hospitals within the Bravo area (Musgrove Park Hospital, Weston General Hospital, Southmead Hospital and the Bristol Royal Infirmary). d) The handover delays meant that there were over 84 hours of ambulance time lost to handovers. This was the equivalent of approximately 7.5 double crewed ambulance shifts which were lost to delays. e) An ambulance was allocated to Mr Whitely at 16.08 hours with an expected time of arrival of 16.30 hours. Had it arrived, Mr Whiteley's ambulance would have taken at least 2 hours and 6 minutes to arrive from the time of the 999 call. f) In the event, Avon and Somerset Police conveyed Mr Whiteley to hospital as the attending Police Tactical Medic was concerned about the ambulance delay and the need for timely assessment at hospital. This meant that the ambulance could be stood down. g) The evidence given by the ambulance Trust at the inquest was that the delays in allocating ambulances caused by the delays in handing over to acute hospitals is continuing.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 27 March 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: [redacted] (Mr Whiteley's daughter) Hummingbird Care Home LLP I have also sent it to the Secretary of State for Health and Social Care, NHS England, ICS, and CQC. 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.
9	**30 January 2025**  **Vanessa McKinlay** **Assistant Coroner for Somerset**