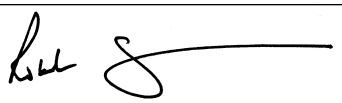
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 CEO – South Central Ambulance Service** **2 NHS England**
1	**CORONER** I am Robert SIMPSON, Assistant 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.
3	**INVESTIGATION and INQUEST** On 23 May 2024 I commenced an investigation into the death of Sandra Ann MILLARD aged 81. The investigation concluded at the end of the inquest on 07 April 2025. The conclusion of the inquest was that: On the 20th May 2024 Sandra Millard was found deceased by her neighbour at her home address in Southcote Lane. She had called 111 for assistance on the 19th May 2024 reporting that she was unable to get out of her chair. As a clinician had not been able to contact her to investigate the reason no ambulance attended until after a neighbour attended the following day.
4	**CIRCUMSTANCES OF THE DEATH** On the 19th May 2024 Sandra called 111 and advised she was unable to move from her chair. The call taker ended the call arranging for a clinician to call Sandra back for a detailed assessment to be carried out. The clinician attempted to call 4 times but Sandra's phone gave an engaged tone on each occasion. The clinician then closed the call without discussing this with their manager. No ambulance was dispatched. On the 20th May 2024 Sandra's neighbour attended the house and found her deceased. At post mortem the cause of death was given as: 1a) Sepsis 1b) Infected leg ulcers 2) Ischaemic heart disease, Coronary artery atheroma & chronic kidney disease.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) I heard that when SCAS call takers using the NHS Pathways triage tool exit a module

	indicating a person is lying on the floor with no reported injuries they are prompted to ask additional questions of the caller; including whether someone else is with the caller; whether the caller can provide a number for next of kin or other person who may be able to attend the caller whilst they wait for an ambulance. This is due to the likely delay of a number of hours before an ambulance can attend. This same procedure is not applied when someone reports that they are stuck in situ, for example they are unable to move from their chair. My concern is that the additional risks of a long lie, for example rhabdomyolosis, may well apply when someone in unable to move from any position. SCAS agreed to change their standard operating procedures to incorporate additional enquiries in these circumstances. I am pleased that they have agreed to amend their procedures swiftly. However this matter has wider significance and should be considered by other users of the NHS Pathways triage tool.
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 June 02, 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 **Sandra Millard's family** I have also sent it to **Association of Ambulance Chief Executives (AACE)** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 07/04/2025**

	 **Robert SIMPSON** **Assistant Coroner for** **Berkshire**