ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Secretary of State for the Home Department – 2. Ministry of Housing, Communities and Local Government CORONER I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire. **CORONER'S LEGAL POWERS** 2 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 21st March 2025, I commenced an investigation into the death of Peter Ramsden, aged 74 years. The investigation concluded at the end of the inquest on 26th June 2025. The conclusion of the inquest was: NATURAL CAUSES CIRCUMSTANCES OF THE DEATH Peter Ramsden had a past medical history of hypertension, impaired glucose tolerance, hyperlipidaemia, poor mobility and chronic alcohol excess. He had not been seen for approximately two months by his neighbours who became concerned about his welfare. Entry to his unlocked premises took place on 2nd January 2025 where he was found deceased and in an advanced state of decomposition. There were no suspicious circumstances or third-party involvement surrounding his death. Whilst no named specific disease process can be identified to account for his death, on balance, it was due to a natural disease process.

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. -

Evidence was heard that there is a lacuna in the law, specifically relating to section 17 of the Police & Criminal Evidence Act 1984 (PACE) which grants police officers the power to enter and search premises without a warrant in specific situations. These include, inter alia, entry for arrest and emergency situations which allows entry to save life or limb or prevent serious damage to a property. In this particular case, evidence was heard that this man had not been seen for two months and there were concerns about his welfare and paramedics attended on one occasion but have no powers of entry. Due to the Right Care, Right Person model, which has been developed over the last few years, the police did not get involved, as it was thought by the concerned individual that this man not being seen was due to a medical problem. Evidence was heard which suggested that on occasions, the ambulance service and the fire service should have powers of entry in the event that a person who is ill, unconscious or otherwise incapacitated, with a remediable disorder, can receive prompt and potentially life-saving treatment. In this case, causation would not have been established as the man has been dead for several weeks, but situations could and will arise where time-sensitive pathological processes require emergency treatment to save life.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action, possibly by considering enhanced powers for the emergency services to enter premises in such circumstances.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th November 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 Chief Executive Yorkshire Ambulance Service;
Chief Executive Humberside Fire & Rescue;
Chief Executive UK Ambulance Service .

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 8th July 2025