Regulation 28: Prevention of Future Deaths report

Dorothy Margaret Hoyberg (died 19 June 2025)

	THIS REPORT IS BEING SENT TO: **1. Secretary of State for Health & Social Care**
1	**CORONER** I am: Melanie Sarah Lee Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 26 June 2025 an investigation was commenced into the death of **Dorothy Margaret Hoyberg** age 70 years. The investigation concluded at the end of the inquest on 12 January 2026. I made a determination at inquest that Dorothy's death was drug related.
4	**CIRCUMSTANCES OF THE DEATH** On 19 June 2025 Dorothy Margaret Hoyberg called 999 for the first time at 08:08 hours. She reported a one week history of a gastric bug and worsening severe pain in the top of her leg since the previous day. A Category 5 disposition was reached and she was advised to call the NHS 111 service. Dorothy did call 111 at 08:27, reporting lower back pain radiating into her groin which was now affecting her breathing. They triaged her as requiring a Category 3 face to face response within 2 hours. This was sent electronically to the LAS dispatch team at 09:24. Dorothy's call was reviewed by a paramedic at 09:28 who confirmed the need for a Category 3 ambulance within 2 hours. On that day LAS were operating at REAP Level 4 (extreme pressure). Multiple attempts were made to find an ambulance resource but LAS were unable to meet targets for Category 3 patients and were

	struggling to meet targets for Category 2 patients. A welfare call back was made at 10:06 hours. At 10:22 a neighbour called 999 at Dorothy's request. He reported her moaning and groaning which he heard again, along with a commotion, at 13:00 hours. A welfare call was made at 10:25 when Dorothy advised worsening abdominal pain going into her leg. The call was re-triaged but the disposition remained a Category 3 ambulance. There is nothing to suggest any errors in the Category 3 disposition. Ongoing attempts were made to find a resource. At 12:25 the last welfare check was made. After this, the demand on LAS was so high that there was no capacity to make any further call backs. At 14:40 a double crewed ambulance was dispatched and arrived at Dorothy's home at 15:03. On arrival, they found Dorothy deceased. At post-mortem, the cause of her leg and abdominal pain could not be ascertained but toxicology revealed elevated levels of morphine and methadone. Dorothy was known to have a long standing history of substance misuse or though as far as her family were aware, she had been stable on methadone for some time.
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. On 19 June 2025 London Ambulance Service (LAS) were operating at REAP Level 4 (extreme pressure) and by 9am that day, targets were being breached. Multiple attempts were made to find an ambulance resource for Dorothy but LAS were unable to meet targets for Category 3 patients and were struggling to meet targets for Category 2 patients. Welfare calls were made to Dorothy until 12:25 at which point the demand on LAS was so high that there was no capacity to make any further welfare calls. Ideally welfare calls should have been made at least every 30 minutes but it was necessary for LAS to prioritise demand and deploy clinicians where they were most needed. Demand outstripped capacity. An ambulance should have reached Dorothy within two hours but it took five and half. I heard evidence that this is a pan-London problem, and it does not appear to be restricted to London. The demand on ambulance services is increasing and the number of patients requiring their services is increasing. Ambulance services are under extreme pressure and this is causing a systems challenge and long delays for patients. LAS are currently operating at REAP Level 4.

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6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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 11 March 2026. 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 following. • Family of Dorothy Hoyberg • London Ambulance Service • HHJ Alexia Durran, the Chief Coroner of England & Wales 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 other 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. 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.
9	**DATE** 14 January 2026 **SIGNED BY ASSISTANT CORONER**