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 NHS England** **2 Chief Coroner**
1	**CORONER** I am Anita BHARDWAJ, Senior Coroner for the coroner area of Sefton, St. Helens and Knowsley
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 25 March 2025 I commenced an investigation into the death of Drew John GREAVES-PIMBLETT aged 26. The investigation concluded at the end of the inquest on 08 January 2026. The conclusion of the inquest was that: Drew Drew John Greaves-Pimblett died as a result of: 1a Sudden Unexpected Death in Epilepsy (SUDEP) b. Epilepsy Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** Drew John Greaves-Pimblett was a 26 year old gentleman who had a medical history of epilepsy. On 22 March 2025, Drew was found unresponsive on the floor of the bathroom of his home address. At 14:11 hours a call was made to the North West Ambulance Service (NWAS), the information provided to the call handler was that Drew was found on the floor unresponsive and not breathing. The call was assessed as a category 1 emergency and an ambulance was allocated at 14:12 hours. As a result of the on-going conversation and confirmation of the fact he was not breathing, at 14:15 hours it was established Drew was epileptic, cold to touch and his finger nails, lips and face were grey. It was also proving difficult for him to be turned over onto his back so he remained on his front. As a result of this information, in accordance with the NWAS pathway, the call handler deemed Drew had not 'just died' and so resuscitation would not be effective. At 14:16 hours the ambulance was stood down and the police notified. At 14.43 hours the police attended and one officer noted Drew was still warm to the touch and so CPR was commenced. The other officer present observed Drew's lips were blue/purple and swollen and his chest was quite stiff making CPR difficult. NWAS were contacted again, and an ambulance arrived at 14:44 hours and Drew was pronounced deceased at 14:46 hours on the same day. A review of the first call made to NWAS revealed the call handler should not have down-graded the call and should not have stood the ambulance down until further probing

	questions were asked. There were no questions asked to establish how cold Drew was ('stone cold' or otherwise), how it was established he was not breathing, whether anyone else was available to help turn Drew onto his back and how stiff Drew was to establish whether rigor mortis had set in. It is impossible to know whether, after the probing questions were asked, the call hander would have reached the same conclusion or whether CPR would have been advised. The absence of the probing questions being a missed opportunity. It would be pure speculation to reach a conclusion that had CPR been carried out it would be a different outcome for Drew. NWAS found the appropriate standard of the call had not been achieved. In all the circumstances it is more likely that not Drew died of natural causes.
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) Though a telephone triage is always challenging and subjective, there appears to be a gap in the national pathways for call handlers. Consideration as to further guidance and assistance to call handlers on probing questioning for fundamental aspects such as breathing and where and how to best assess how cold the body is. If someone is not breathing to ask how they know and/or techniques such as head to the chest, where to take a pulse etc. for the call handler to make a more informed decision as to whether someone is breathing and if CPR is required. When a call is made to NWAS, often it is by someone not thinking straight and so specific questions on breathing and general presentation may be of assistance in assessing the call.
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 March 05, 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 Chief Coroner and to the following Interested Persons **1. North West Ambulance Service** **2. [redacted] (spouse – next of kin)** **3. [redacted] (brother-in-law – point of contact for family)** I have also sent it to 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. 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: 08/01/2026** [redacted] **Anita BHARDWAJ** **Senior Coroner for** **Sefton, St. Helens and Knowsley**