



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. NHS England</p>
1	<p>CORONER</p> <p>I am Mr Paul M Appleton, HM Area Coroner for the Coroner Area of Teesside & Hartlepool.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 15 March 2019 an investigation was commenced into the death of Peter COATES, aged 62 (born 13.04.1956). The investigation concluded at the end of the inquest on 20.03.2026. The conclusion of the inquest was a narrative conclusion as follows:</p> <p><i>“Peter died due to complications of Very Severe Chronic Obstructive Pulmonary Disease, with his death contributed to by the consequences of Obesity. Peter would not have died when he did, in the absence of an unplanned electrical power supply failure to his home address which caused his mains operated, bilevel positive airway pressure (BiPAP) and oxygen concentrator equipment to stop working.”</i></p> <p>I found Peter’s medical cause of death to be:</p> <p>1a) Complications of Very Severe Chronic Obstructive Pulmonary Disease. 2) Obesity.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Peter Coates’ past medical history included Very Severe Chronic Obstructive Pulmonary Disease (“COPD”) and Obesity. Peter sadly died at his home address of 42 Boulby Road, Redcar on 14.03.2019.</p> <p>Due to the severity of his COPD, Peter was reliant on at home, mains operated, clinical equipment, namely a bilevel positive airway pressure (BiPAP) machine and an oxygen concentrator.</p> <p>At 03:57 on 14.03.2019, Peter’s home address lost electrical power due to an unplanned electrical power supply failure.</p> <p>At 04:01, Peter contacted 999 and spoke to a Health Advisor at the North East Ambulance Service NHS Foundation Trust. During this telephone call, information provided by Peter included that: he had COPD and used an oxygen machine but there had been a power cut, he was struggling to breathe, could not reach his portable oxygen cylinders, and was home alone. Peter also confirmed the approximate location of, and the code for, a key safe at his home address. The key safe code was included in the crew notes subsequently made available to the attending Paramedics; however, the approximate key safe location was not included in the crew notes.</p>



	<p>A category 2 emergency ambulance response was assigned to Peter. I heard that the national Ambulance Response Programme requires, for category 2 responses, an overall average response time within 18 minutes, and a response to 90% of category 2 calls within 40 minutes.</p> <p>An ambulance crew was allocated to Peter at 04:04. That ambulance crew had an expected journey time to Peter's home address of 1 minute and 37 seconds. That ambulance crew was, however, unable to depart from the ambulance station, due to the power failure meaning the electrically powered station gates would not open, with relevant staff being unaware of how to manually open the station gates.</p> <p>At 04:15, the category 2 emergency ambulance response to Peter was reallocated to a different ambulance crew. That ambulance crew, whilst travelling to Peter's home address, stopped at a petrol garage to refuel at 04:23, leaving the petrol garage at 04:27, and arriving at Peter's home address at 04:38. Following their arrival, the attending ambulance crew were initially unable to find the key safe and/or gain access to Peter's property. Having located the key safe, the ambulance crew gained entry to Peter's property at or around 04:48 and shortly thereafter found Peter to sadly be deceased on his bed. It was noted by the attending ambulance crew that Peter had obtained a portable oxygen cylinder, which was not dependent on a mains electricity supply, and which was delivering oxygen via a nasal cannula.</p> <p>The electrical power supply to Peter's property was restored at 05:14 on 14.03.2019.</p> <p>Peter died due to complications of Very Severe COPD, with his death contributed to by the consequences of Obesity. Peter would not have died when he did, in the absence of the unplanned electrical power supply failure.</p> <p>Peter's death was possibly contributed to by delays in the arrival of the ambulance crew to him.</p> <p>I heard evidence at the inquest hearing that a category 1 emergency ambulance response could not have been generated for Peter, as he was breathing and conscious at the time of the 04:01 999 telephone call.</p>
<p>5</p>	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows:</p> <p>In respect of the National Ambulance Response Programme, I understand from the evidence that:</p> <ul style="list-style-type: none"> - Category 1 is an immediate response to a life-threatening condition. It should only be used for a patient who requires resuscitation or emergency intervention from the ambulance service, for example, a patient who is in cardiac or respiratory arrest. Mortality rates are high where a difference of one minute in response time is likely to affect outcome and there is evidence to support the fastest response. The national standard is for 90% of Category 1 patients to have received a response within 15 minutes; and for the overall average response time to be within 7 minutes. - Category 2 is for serious conditions, for example stroke or chest pain, that may require rapid assessment and/or urgent transport. Mortality rates are lower; a difference of an extra 15 minutes' response time is unlikely to affect outcome and there is evidence to support an early dispatch. The national standard is for 90% of patients to have received



	<p>a response within 40 minutes; and for the overall average response time to be within 18 minutes.</p> <p>My concern is that there are circumstances in which a patient is not, at the time a 999 call is made to request an Ambulance, in a condition such as cardiac or respiratory arrest; but where an immediate response is still required on the basis that delay in ambulance attendance could pose a risk to their life. That is, I am concerned that there is a category of patients who do not meet the criteria for a category 1 response, but who do nonetheless require an immediate response, and that there is, therefore, a “gap” between categories 1 and 2. This includes for patients who are alone at the time of calling 999 and who are therefore unable to update the Ambulance Service should they progress to cardiac or respiratory arrest.</p>
<p>6</p>	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
<p>7</p>	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 May 2026. I, the Coroner, may extend the period.</p> <p>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.</p>
<p>8</p>	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ol style="list-style-type: none"> 1. Peter’s Family. 2. North East Ambulance Service NHS Foundation Trust. <p>I have also sent it to:</p> <ol style="list-style-type: none"> 1. Association of Ambulance Chief Executives (AACE). <p>who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
<p>9</p>	<p>Dated: 23 March 2026</p> <p></p> <p>Mr Paul M Appleton HM Area Coroner for the Coroner Area of Teesside & Hartlepool.</p>