REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Joanne ANDREWS, Area Coroner, for the coroner area of West Sussex, Brighton and Hove.
2.	**DATE OF REPORT** 15 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. NHS England & NHS Improvement (reg 28 reports) 2. South East Coast Ambulance Service NHS Foundation Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by August 10, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6.	**CORONER'S CONCERNS** I heard evidence as to the operation of the NHS Pathways system which raises concerns about information that is provided to patients as to the attendance of the Ambulance service to them.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 07 October 2025 I commenced an investigation into the death of Daniel Charles FORREST aged 85. The investigation concluded at the end of the inquest on 11 June 2026. The conclusion of the inquest was that: Daniel Charles Forrest died on 1 October 2025 at East Surrey Hospital, 1 Canada Avenue, Redhill, Surrey from an unsurvivable head injury. He had a witnessed fall outside his home address falling onto a curb on 30 September 2025. An ambulance was called but due to a significant delay was cancelled by Mr Forrest before they attended. There is insufficient evidence from which I can conclude that this contributed to the death. He then had an unwitnessed fall at his home address on 1 October 2025 when emergency services attended and conveyed him to hospital where he sadly died.

9.	**CIRCUMSTANCES OF DEATH** Mr Forrest was an 85-year-old gentleman who fell outside his home at around 17:12 hrs hitting his head on a curb. A bystander called Southeast Coast Ambulance Service NHS Foundation Trust ("SECAMB") at that time but his son and daughter-in-law were also present. The call was triaged using the NHS Pathways system which concluded that he needed a Category 3 response which at that time had a target response time of 120 minutes. The contact details of the family members who were present with Mr Forrest were taken. At the time of the call being made SECAMB was in Clinical Safety Plan level 3. The Pathways call closing script told the Emergency Medical Adviser who took the call on behalf of SECAMB that they should tell the caller that "an ambulance was being arranged" which they did. In addition to the NHS Pathway script, the Emergency Medical Adviser told the caller that the estimated time of arrival for the ambulance would be 3 hours and 47 minutes. An ambulance was not dispatched at that time as category 3 calls then are validated by clinicians before being added to the dispatch queue. Clinicians attempted to call back for this reason but were unable to make contact as only the contact number of a bystander rather than the family with Mr Forrest was identified on the CAD system. The callbacks were attempted at 20:42 and 21:02. As such the call was added to the dispatch queue 21:05 hours but there was no ambulance available to be allocated to Mr Forrest due to the significant number of calls outstanding in higher categories for response and earlier timed calls in category 3. At 21:48 the family called SECAMB as there had now been 4 hours and 36 minutes since the initial call. The Emergency Medial Adviser did not re-triage the call and therefore no updated estimated time of arrival for the ambulance was provided. At that time the Emergency Medical Adviser did discuss whether Mr Forrest could self-convey to hospital and worsening care advice was given. At 23:45 the family called SECAMB again to cancel the Ambulance as Mr Forrest wanted to go to bed and they had been waiting for 6 hours and 33 minutes. He spoke directly with SECAMB and the call was closed by SECAMB after clinical review. The family indicates that they would be staying with Mr Forrest. Around 01:20 on 1 October 2025 the family found Mr Forrest had fallen in the house and sustained further injury. SECAMB were called and the call was triaged using the NHS Pathways system as a category 3 response. At that time, there were 138 calls outstanding including 20 category 2 calls and 110 category 3 calls outstanding. An estimated time for attendance was requested by the family but this was not produced. Worsening care advice was given. At 02:06 Mr Forrest had deteriorated and therefore the family contacted SECAMB again and the call was re-triaged with the additional new symptoms as category 2. The ambulance arrived to assist Mr Forrest at 02:23 on 1 October and he was conveyed to hospital. Sadly he was found to have an unsurvivable head injury from which he died

	later that day.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: I heard that the NHS Pathways system tells call handlers to advise callers that an ambulance is being arranged. However I heard that within SECAMB category 3 and category 4 dispositions are validated by clinical staff before being added to the Dispatch queue for an Ambulance to be allocated. I heard that this was in line with National Guidance from The Association of Ambulance Chief Executives. Therefore, callers are not informed that no ambulance is being arranged at the time of their call. I also heard that the NHS Pathways does not allow callers to be advised of the estimated time that they may have to wait for ambulance attendance. The evidence was that SECAMB have requested that the wordings provided by NHS Pathways be altered so that there is provision to give further information to callers about how long they may wait for an ambulance to attend but this has previously been declined by NHS England. I consider that both of the above matters mean that patients cannot make informed decisions about whether they wait for the arrival of an ambulance or escalate worsening symptoms on the basis that they anticipate that an ambulance is being arranged so will be with them shortly when this may not be the case.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • **Family of Mr Forrest** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

12.	**SIGNATURE**  **Joanne ANDREWS** **Area Coroner for** **West Sussex, Brighton and Hove**