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. **London Ambulance Service** Legal Services London Ambulance Service NHS Trust 220 Waterloo Road London SE1 8SD
1	**CORONER** I am Andrew Walker, senior coroner for the coroner area of Northern District of Greater London
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 28th Day of March 2013 I commenced an investigation into the death of Mark Stephen Smith aged 52 years old. The investigation concluded at the end of the inquest on 16th October 2013 . The conclusion of the inquest was a narrative conclusion Mark Smith having died of Zopiclone and Mirtazapine overdose complicated by ethanol use with chronic obstructive pulmonary disease and coronary artery atheroma under paragraph 2. On the 2nd March 2013 Mr Smith telephoned for an ambulance having intentionally taken more of his medication than the dose prescribed by his doctors. There was a delay from 8.57 and 53 seconds, when an ambulance should have reached Mr Smith, to 11.18 and 17 seconds when the ambulance arrived to assist Mr Smith. This delay was the result of a recognised mismatch between capability and demand and on the 2nd March 2013 between 3am and 2pm there were 15 and 20 ambulances short pan-London. This delay was likely to have contributed to Mr Smith's death.
4	**CIRCUMSTANCES OF THE DEATH** Following Mr Smith's call to the London Ambulance Service the Emergency Medical Despatcher obtained the correct determinant for the response ,(a response under 30 minutes). When taking a call from a person threatening suicide and who is alone, as Mr Smith was, the instruction within the operating procedure OP060 is that the fact that the caller is alone should be documented and the Emergency Medical Despatcher should stay on the line with them where possible. The Emergency Medical Despatcher did not note that Mr Smith was alone and did not stay on the line with Mr Smith. Had these steps been taken it may have been possible to

	recognise at an earlier stage when Mr Smith, who, although the Emergency Medical Despatcher did not know this, had taken medication that would render him unconscious within 30 to 45 minutes. This significance of this would be that had Mr Smith fallen unconscious and the Emergency Medical Despatcher had known this the call would have been upgraded to a response within 8 minutes.
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. – Consideration to be given to giving guidance on what "where possible" in the terms of the above section of OP060 and whether a supervisor should be consulted before the decision is taken not to stay on the line where a person has taken an intentional overdose and is alone.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 17th December 2013. 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 AvMA (representing members of the family) and [redacted] of Eastwoods Solicitors (representing [redacted] 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	21 OCT 2013