Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Department of Health** Department of Health Richmond House 79 Whitehall London SW1A 2NS
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 the 30th July 2013 I opened an inquest touching the death of Graham James Sutton, aged 65 years old. The investigation concluded at the end of the inquest on the 17th February 2014. The conclusion of the inquest was "Accident", the medical case of death was ;1a Subdural Haemorrhage (operated 11.7.2013) , 1b Head Injury.
4	**CIRCUMSTANCES OF THE DEATH** On the 10th July 2013 Graham James Sutton fell 5 feet from a ladder and struck his head on concrete whilst cutting a hedge. Mr Sutton was able to get up and took himself to bed. Mr Sutton was then taken by ambulance to hospital before being transferred to a Trauma Centre where despite treatment he died.
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. – (1) The fact that Mr Sutton had fallen as little as 5 feet, that he was over 50 years old and that he was taking anti-clotting medications, (Clopidogrel), were not linked automatically by the London Ambulance Service to result in a response within 8 minutes.
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 Monday 21st March 2014. 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 London Ambulance Service and members of the family. 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	**24st February 2014**