Regulation 28: Prevention of Future Deaths report

Toni Elizabeth SKILLINGTON (died 01.04.14)

	THIS REPORT IS BEING SENT TO: **1. Ms Ann Radmore** **Chief Executive** **London Ambulance Service NHS Trust** **220 Waterloo Road** **London SE1 8SD**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 4 April 2014, one of my assistant coroners, Richard Ian Brittain, commenced an investigation into the death of Toni Elizabeth Skillington, aged 43 years. The investigation concluded at the end of the inquest on 30 July 2014. The determination I made at inquest was as follows. "Toni Skillington took an excess of methadone and alcohol, but did not intend to take her own life. She called family members soon after, and they alerted London Ambulance Service, but it took almost three hours for emergency paramedics to arrive, during which time there was a failure to act within LAS protocols. The opportunity to attempt to save Toni Skillington's life was lost. This was an accidental death."

	The medical cause of death was: 1a mixed methadone and alcohol toxicity 2 liver cirrhosis.
4	**CIRCUMSTANCES OF THE DEATH** On the evening of Tuesday, 1 April 2014, Ms Skillington telephoned family members including her son, [redacted] having drunk an excess of alcohol, saying that she had taken an overdose of methadone. (Her husband had recently died.) Ms Skillington had been prescribed methadone in the past, but by that time not for a year. [redacted] telephoned London Ambulance Service (as did Ms Skillington's brother) at 7.30pm and explained the situation, including the fact that he was not with his mother at that time. The call handler did not know that methadone is a narcotic and did not ask her supervisor, so marked it as an overdose of "other". The call was prioritised as C2, with a target response time of 30 minutes. As this was an extremely busy night with a staff shortage, no ambulances were available for C2 calls, so two ring backs were made to make welfare checks, at 8.21pm and 9.42pm. There was no reply on either occasion. According to operational procedures, this should have prompted the following steps. - A call to local hospitals to check if the patient had arrived by other means. - Validation of the contact details and address displayed on the screen. - An alert to the police of a possible collapse behind locked doors. - Notification to the clinical hub to consider upgrading the call. None of these steps was taken following either of the two ring backs. A paramedic team leader did response profile the call at 8.56pm, but he was not told of the fact that a ring back had been made with no reply. If he had, he would have upgraded the call immediately. In the event, he put a clinical flag on the call, intending to return to this when he had reviewed all the calls being held. However, he then attended to other duties and so the call was not upgraded. A new call allocator came on duty at 9.30pm, and made a further welfare check at 9.54pm. When she received no reply, she dispatched one and then another vehicle. When each of these was diverted to a red call, she dispatched a third at 10.11pm and asked that the call be upgraded, which it was, ensuring that the vehicle was not diverted.

	This call allocator also gave evidence that if she had been on duty earlier, she would have upgraded the call sooner. An ambulance finally arrived at Ms Skillington's home at 10.24pm and gained entry ten minutes later, but the crew found her already dead.
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 Medical Priority Dispatch System (MPDS) does not include methadone as a one of the drug choices following an overdose, despite the fact that it is commonly taken in excess. I understand that the LAS has written to the National Academy for Emergency Medical Dispatch about this. 2. The MPDS does not ask specifically whether the patient is alone, though it is recognised that this renders a patient particularly vulnerable. I understand that the LAS has also written to the National Academy for Emergency Medical Dispatch about this. 3. Two welfare checks were made via ring backs without any reply gained, yet neither of these was followed by the appropriate action. Even accepting how busy and under staffed the service was that night, a call could at least have been made to the police asking for attendance. 4. London Ambulance Service received a call describing an intentional methadone overdose, taken with alcohol, and yet no paramedic responded until three hours later.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 29 September 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] Ms Skillington's son • Professor Dame Sally Davies, Chief Medical Officer for England • NHS England 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 31.07.14