REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

*NOTE: This form is to be used **before** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NORTH EAST AMBULANCE SERVICE, NHS Foundation Trust** **2. NORTHUMBRIA POLICE SERVICE** **3. CUMBRIA, NORTHUMBERLAND, TYNE & WEAR NHS TRUST**
1	**CORONER** I am TERENCE CARNEY, Senior Coroner, for the coroner area of Gateshead & South Tyneside
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** On 16th November 2018 commenced an investigation into the death of MAUREEN WHARTON aged 61. The investigation has not yet concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** 1. On Thursday 15th November 2018 at 20.45 Maureen contacted 999 ambulance services. 2. She stated that she was dying of cancer and that she wanted to end her life now. 3. She stated she had taken a quantity of medication including Tramadol, Zopliclone and other prescribed medication and she claimed she was still taking them. 4. She claimed to be in possession of paracetamols but had not taken these yet 5. She stated she suffered from depression and had previously overdosed. 6. Ambulance Control allocated this incident a Grade 3 response - a potential response time of 125 minutes. 7. At 2112 Maureen again contacted the Ambulance Service, confirming the same previous detail given. She stated she was not "worse". She appeared slightly more drowsy but was able to communicate. 8. At 0010 an ambulance was assigned to the incident and arrived at Maureen's flat at 0017. 9. Entry was eventually gained to the flat at 0030. 10. Maureen was deceased 11. A subsequent post mortem examination confirmed death was attributable to "the combined effects of Tramadol, Venaflaxine, Zopliclone and alcohol

5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows. – The Investigation of the circumstances of the death has focused amongst other aspects on the control communications between Maureen and Ambulance control personnel with particular reference to the detail of the actual conversations had between Maureen and the personnel, the method of evaluating and grading of information elicited from Maureen in that process. It is correct to acknowledge the NEAS is still undertaking its own investigation and evaluation of these matters with a view to publishing a report before the end of the current year, concerns have been identified around apparent missed opportunities to react in a different or more timely manner to the facts and detail being presented in the course of these calls. Central to these concerns are that a period of 3.45 hours elapsed between the first call and the arrival of an Ambulance crew at Maureen's side. Whilst explanations around lack of resources and even possibly inadvertent allocation and/or interpretation of data may feature in the NEAS subsequent report by way of explanation of this delay, the real and imminent danger of Maureen's admitted actions does not appear to have been appreciated and readily reacted to in a meaningful way given the danger they clearly presented. An apparent toxicological aid was either unappreciated or misinterpreted as an under assessed and immediate event - the need was obvious a) No enquiry was made of Maureen as to the nature of her location and the potential support or assistance readily at hand or otherwise. b) No further enquiries were made to identify familial or social support which might or could have been enlisted or alerted to her presenting danger c) No NEAS protocol appears to exist to assist personnel to initiate a response other than one limited to and directing an ambulance allocation d) No working arrangement appears to exist to enlist the aid of other Agencies to support the patient or react more directly and in timely way to monitor and evaluate the nature of the presenting danger. There appears to be a need for a closer liaison and working relationship between Emergency Services which is sufficiently robust to react and present early support to the patient there having been such an accurate evaluation of an otherwise obvious developing critical situation and particularly if delays in reaction otherwise may also be apparent.
6	**ACTION SHOULD BE TAKEN**

	In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has the power in concert with others identified 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 **1st February 2020**. 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 the family of Maureen Wharton and their representatives. 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	**6th December 2019** CORONER GATESHEAD AND SOUTH TYNESIDE