Regulation 28: Prevention of Future Deaths report

David Anthony SWEENEY (died 25.04.15)

	THIS REPORT IS BEING SENT TO: **1. Dr Fionna Moore** **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 30 April 2015, I commenced an investigation into the death of David Sweeney, aged 28 years. The investigation concluded at the end of the inquest yesterday. I made a determination at inquest as follows. "David Sweeney's death was alcohol related. An opportunity for earlier medical intervention – which might have saved him on this occasion – was lost when a call to the ambulance service was not categorised as a priority." The medical cause of death was: 1a hypoxic brain injury 1b acute alcohol toxicity

4	**CIRCUMSTANCES OF THE DEATH** A member of the public called London Ambulance Service at 4.47pm on 18 April 2015, to report that he could see a man [Mr Sweeney] lying on the ground vomiting. The caller said that the man had been unconscious. In response to the LAS emergency medical despatcher's question asking if he was now a little bit awake, the caller replied yes. The EMD then incorrectly selected the protocol for a sick person instead of the protocol for an unconscious person, and so the call did not receive a categorisation of red 2, target arrival time of 8 minutes, which it otherwise would have done. Instead, a clinical adviser rang back, categorised it as a C1, and an ambulance arrived 1 hour 40 minutes after the original call, prompted then by a call from the Metropolitan Police Service who had come upon Mr Sweeney. Just a few minutes before LAS arrived, Mr Sweeney suffered a cardiac arrest and consequent hypoxic brain injury, from which he died a week later. One of the intensive care consultants who looked after Mr Sweeney in the following days, gave evidence that if Mr Sweeney had been in hospital at the time of his cardiac arrest, he probably would have survived.
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. A call to the London Ambulance Service regarding a man who had been unconscious did not prompt a red prioritisation. You will remember that I wrote to you on 27 May 2015, regarding the assumption made by an LAS EMD that a child was asleep but rousable, when in fact the little boy was likely to have been unconscious. I am extremely concerned that a theme may be emerging in the handling by LAS of calls regarding unconscious patients.

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 19 October 2015. 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 • Association of Ambulance Chief Executives (AACE) • National Ambulance Service Medical Directors (NASMeD) • Professor Dame Sally Davies, Chief Medical Officer for England • NHS England • [redacted], wife of David Sweeney • [redacted], Ms Mary McCarthy, sisters of David Sweeney • [redacted], consultant in intensive care 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** 19.08.15