

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. London Ambulance Service NHS Trust.</p>
1	<p>CORONER</p> <p>I am Jonathan Landau, assistant coroner for the coroner area of South London</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 26 November 2019, an investigation was commenced into the death of Raphael Jeffery Gill. The investigation concluded at the end of the inquest on 9th February 2022.</p> <p>The jury returned the following narrative conclusion:</p> <p>“Raphael Gill was stopped by traffic Police for speeding, and arrested for drug related offences. He suffered three seizures in the police care, and one in the ambulance. The London Ambulance Service were called during the first seizure, and Police chased this multiple times, but delays occurred as the London Ambulance Service were directed to the A2 instead of the A20. His condition was not perceived as a medical emergency so was not blue lighted to hospital. Raphael was assessed as Triage category three, which delayed the time to be seen. A venous blood gas test was requested, but not performed until it was too late. An ECG was not completed in the hospital. The VBG omission led to a delay in treatment, and possibly contributed to Raphael’s death. Raphael was in the waiting room for 96 minutes, and not seen by a Dr until his fifth seizure occurred, which led him being moved to a cubicle. Shortly after entering the cubicle, Raphael suffered a sixth and final seizure. The cause of Raphael’s death include a combination of his underlying seizure disorder, cocaine, and prescribed medications, which all lowered the threshold for seizures, creating a permissive environment for multiple seizures to occur. Cause of death, Multiple Seizures”</p> <p>The medical cause of death was give as:</p> <p>1. a Multiple Seizures b Underlying Seizure Disorder, Cocaine and Prescribed Medication</p>

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>See above.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) The evidence of the medical expert was that Mr Gill was so unwell by the time he arrived at hospital that it was more likely than not that his life was not rescuable with sooner treatment. Whilst Mr Gill was taken to hospital, it was not under blue lights and sirens, and the most senior clinician drove so was not on hand to provide emergency treatment that the technician was unqualified to provide. It was apparent that the ambulance crew were not aware that the combination of seizures and cocaine represented a medical emergency, a fact expressly found in the jury's conclusion.</p> <p>(2) Whilst it was reasonable for the LAS staff to suspect a link between the arrest and seizures, the arrest unduly influenced the assessment of urgency.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report,</p>
	<p>namely by 22 June 2022. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>

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Jonathan Landau, HM Assistant Coroner
27 April 2022