North Tyneside Coroners
MRS KAREN L DILKS
HM ACTING SENIOR CORONER
Civic Centre , Barras Bridge , Newcastle Upon Tyne , NE1 8QH
[redacted]

Date: 14 September 2022
Case: 9901622

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] **Chief Executive North East Ambulance Service**
CORONER

1 I am **Karen Dilks Senior Coroner** for **Newcastle and North Tyneside**

CORONER'S LEGAL POWERS

2 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 21 October 2021 I commenced an investigation into the death of Adam GALLAGHER. The investigation concluded at the end of the inquest . The conclusion of the inquest was

3 Adam GALLAGHER died due to his own actions whilst under the influence of alcohol to which a missed opportunity for urgent intervention contributed.

1a Pressure on the Neck

1b Hanging

1c

II

CIRCUMSTANCES OF THE DEATH

4 Adam Gallagher was 30 years old. He had a history of Mental health issues and alcohol Dependence Syndrome. On 17th October 2021 whilst under the influence of Alcohol he communicated suicidal ideation by text message to a friend who shared this information and details of his mental health history, including previous hospital admission under MHA 1983 with NEAS via 999call.

NEAS Health Advisor contacted AG by telephone; the call was short ,only limited

assessment of his Capacity and Risk was undertaken, No Clinical input was sought and Ambulance was NOT dispatched.

At around 9am on 18th October AG was found [redacted] where his death was confirmed.

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) NEAS Trust confirmed in evidence that a more detailed assessment of AG should have been undertaken and Clinical input sought leading to Ambulance dispatch and potentially an
5 alternative outcome for AG. Learning from the incident was limited to 'discussion' with 2 staff involved.

Serious events of this nature should be subject of Trust wide learning and training to prevent future deaths.

(2) Comprehensive retraining is required for those directly involved.

(3)An urgent review of Trust policy/protocol for handling/management of mental health related incidents should be undertaken and associated training in respect thereof.

(4)Trust to review the events leading to AG's death and identify any additional safeguards they may put in place to prevent future deaths.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you [redacted] have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 10th November 2022. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted]. I have also sent it to [redacted], Chief Executive, Cumbria, Northumberland, Tyne & Wear Trust who may find it useful or of interest.

8 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.

14 September 2022

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for North Tyneside Coroners