REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. STEVE GARGON Chief Constable Avon and Somerset Constabulary**
1	**CORONER** I am Michael Richard ROSE, Senior Coroner for the West Somerset area
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 and INQUEST** On 13 November 2023, I commenced an investigation into the death of Jack William PAYTON deceased at 85 years. The investigation concluded at the end of the Inquest on 12 August 2013. The Conclusion of the Inquest was natural causes and the cause of death was: 1a Ischaemic Heart disease
4	**CIRCUMSTANCES OF THE DEATH** The deceased was driving home to Cossington after attending a dialysis session at Taunton when at approximately 5.30 pm on 17th October 2012 his car veered off the carriageway of the A38 road at Bathpool to go down an embankment on his nearside. The incident was reported to the Police Control Room at Portishead ("Portishead") at 7.20pm but no action was taken after the report was downgraded to "schedule" The deceased's absence was reported to Portishead at 8.51 pm by a member of his family but although action was taken to check the A38 between Bridgwater and Taunton the deceased was not found until 25 minutes after midnight the following morning following a review of closed logs which led to a more precise identification of the scene. The pathologist at the subsequent post mortem found the deceased died of Ischaemic heart disease but was not able to confirm whether or not the deceased would have died if his body had been found earlier.
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:-** At the Inquest two members of the control room staff at Portishead namely [redacted] by their replies to my questions and demeanour conveyed to me the distinct impression that the hours they worked together with their case load had a detrimental affect on their judgement and subsequent handling of this matter.
6	**ACTION SHOULD BE TAKEN** That the existing hours of work in an enclosed environment, namely four shifts of 10 hours followed by two shifts of 7 hours should be examined by an experienced physiologist to ascertain whether or not the work pattern is reasonable for people of the age and experience undertaking this type of work.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 . 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	**[DATE]** 30.VIII.13 **[SIGNED BY CORONER]**