IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Rajesh PARKASH
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: The Chief Executive of the London Ambulance Service, and The Chief Executive of the Association of Ambulance Chief Executives
1	**CORONER** Richard Travers HM Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into **Rajesh Parkash's** death was opened on the 19th March 2013 and was concluded, following an adjournment, on 29th April 2014. The cause of death was: 1a – Multiple Injuries. I concluded with a narrative conclusion: Mr Parkash died as a result of accidentally colliding with an ambulance that had been left parked in a dangerous position obstructing lane 3 of the southbound A3 in Surrey. The driver of the vehicle and the supervising paramedic failed to undertake any or any effective risk assessment of the dangers that the ambulance posed to others by reason of the position in which it had been left. In addition, by leaving or allowing the ambulance to be left in that position, they failed to follow the letter or the spirit of the guidance and / or directions given by the LAS to all their staff relating to their duty to protect the safety and wellbeing of their patients, passengers, and most importantly in this case, other road users.
4	**CIRCUMSTANCES OF THE DEATH** At shortly before 10.00 hours on the 14th March 2013 Mr Parkash, a 43

	year old dentist and father of two, was riding his BMW motorbike southbound on the A3. A short distance beyond the Hook underpass, at which point the A3 is a three lane highway, his motorcycle collided with the rear, nearside corner of an ambulance which had been parked in lane 3 of the A3.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a number matters that gave rise to a concern that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken. The **MATTERS OF CONCERN** are as follows. – 1. Action is required to ensure that ALL updates and bulletins advertised on the Routine Information Bulletin are seen and read by all relevant members of staff in a timely manner. 2. Action is required to ensure that all relevant staff fully understand that the measures and restrictions included in the Trust's training and guidance that apply to motorway driving apply equally to ALL multi-lane highways regardless of their designation. 3. Consideration should be given to ensuring that the role of a supervising paramedic extends to all aspects of their work, including driving, and is not limited to clinical decisions. 4. Consideration should be given to imposing some form of minimum experience requirement before a paramedic is able to act in the role of a supervising paramedic. 5. Consideration should be given to providing to all relevant staff regular, on-going driver training over and above the anticipated statutory requirement for a five year assessment. 6. Action is required to improve communications between the control room and the personnel within an ambulance that is answering a call. 7. Action is required to improve communications between the London Ambulance Service and those ambulance services which border its area, such as the South East Coast Ambulance Service.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Chief Executive of the London Ambulance Service, and the Chief Executive of the Association of Ambulance Chief Executives have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the Interested Persons in the Inquest and the Chief Coroner.
9	**Signed:** *Richard Travers* **DATED this 8th day of May 2014**