Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Department of Health** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 the 9th October 2012 I opened an inquest touching the death of Liam Martin Coleman, 57 years old. The investigation concluded at the end of the inquest on the 12th May 2014. The conclusion of the inquest was "Narrative ", the medical case of death was 1a Acute Left Ventricular failure 1b Coronary and Hypertensive Heart Disease and Chronic Obstructive Pulmonary Disease 2 Morbid Obesity.
4	**CIRCUMSTANCES OF THE DEATH** On the 3rd October 2012 Liam Martin Coleman at 2.25 hrs in the morning Liam Martin Coleman collapsed at his home. A call was put through to the London Ambulance Service at 2.49 hrs. A second call was put through to the London Ambulance Service at 03.00 hrs. Following the second call a Fast Response Unit was despatched arriving at 3.20 hrs with the crew at Mr Coleman's side by 3.22 hrs. An ambulance was despatched at 3.18 hrs arriving at 3.28hrs with the crew at Mr Coleman's side by 3.29hrs. A further ambulance was despatched when it became available at 3.44 hrs arriving at 3.49hrs with the crew at Mr Coleman's side by 03.49 hrs. London Ambulance Staff provided advanced life support until at 4.43 hrs when London Ambulance Staff confirmed that Mr Coleman had died. Information from the London Ambulance Service at the inquest indicated that ambulance availability was around 75% of the planned hours including any unstaffed vehicles and vehicles that were out of service. The service average for the year 2012 to 2013 was 80%. In these particular circumstances the delay did not, on the balance of probability, more than minimally or trivially contribute to Mr Coleman's death.

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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. – That there were insufficient ambulances available to cover the number of Red 1 and Red 2 calls in the early hours of the morning of the 3rd October 2012.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 Tuesday 5th November 2013. 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 Chief Coroner and to the following Interested Persons Members of the family and the LAS 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	**25th May 2014**