REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Mr Jeremy Hunt, Secretary of State for Health **2.** Chief Executive, North West Ambulance Service
1	**CORONER** I am M Jennifer Leeming H M Senior Coroner, for the Coroner Area of Manchester West
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 3rd May 2013 I commenced an investigation into the death of Caroline Louise Pilkington, who was 30 years of age. The investigation concluded at the end of the inquest on 19th March 2014. The conclusion of the inquest was that Caroline Louise Pilkington's death was due to an accident. The medical cause of her death was 1a) Propranalol Toxicity
4	**CIRCUMSTANCES OF THE DEATH** On the 25th April 2013 Caroline Louise Pilkington was found apparently suffering from a fit in her upstairs bedroom at her home address. The North West Ambulance Service was called and three paramedics attended. Due to the violence of Miss Pilkington's movements in the course of her fit it was necessary to restrain her limbs in order to remove her safely from her home. In the circumstances the North West Ambulance Service personnel called the police service to assist them. Officers of Greater Manchester Police attended, applied restraints to Miss Pilkington and assisted in removing her safely from her home.
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: North West Ambulance Service personnel are not trained in control and

	restraint techniques. Evidence was therefore given at the inquest that it was necessary for them to call the police service to assist them in dealing with patients who are unwell where the use of such techniques is required. This is so despite the fact that other clinical personnel, for example Mental Health nurses, are trained in such techniques. In the case of Miss Pilkington this resulted in three paramedics having to call for assistance from the police service. Evidence revealed that calling the police in these circumstances results in patients who are physically and/or mentally unwell being dealt with by the police service, who, although they are trained in control and restraint techniques, are not clinically trained to deal with such patients. In addition, further evidence was given that the involvement of the police service in these cases not only potentially results in inappropriate removal of police officers from their core policing duties, but also potentially results in harm to patients being caused by delaying their removal to hospital.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.	
/037	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th May 2014. 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, [redacted] Caroline Pilkington's mother), [redacted] (Caroline Pilkington's partner). I have also sent it to Theresa May The Home Secretary and Sir Peter Fahy, The Chief Constable of Greater Manchester Police who may find it useful or of interest. 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	**Dated** **25th March 2014**	**Signed** **M Jennifer Leeming**