## ANNEX A

## **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. West Midlands Ambulance Trust 3. 1 CORONER I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire 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. **INVESTIGATION and INQUEST** 3 On 17<sup>th</sup> April 2014 I commenced an investigation into the death of Caroling Carter Crowther then aged 65 years. The investigation concluded at the end of the inquest on 23<sup>rd</sup> September 2014. The conclusion of the inquest was natural causes the medical cause of death being 1(a) bronchopneumonia, 1(b) acute exacerbation of chronic obstructive pulmonary disease, 2 pyometra, idiopathic left ventricular hypertrophy. **CIRCUMSTANCES OF THE DEATH** Mrs Crowther was a patient detained by virtue of Section 3 of the Mental Health Act. Her physical health deteriorated and the psychiatric clincians called for an emergency ambulance to take her to Worcestershire Royal Hospital. The paramedics who attended took the view that she did have capacity to refuse medical treatment nowithstanding the view of the consultant psychiatrists and declined to take her to Worcestershire Royal Hospital. the following day Mrs Crowther's health deteriorated further and she died. 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. -(1) The Paramedic who gave evidence expressed a view that it was "Trust Policy" that a psychiatric patient whether or not they had capacity should not be compelled to go to hospital even when it was universally agreed that she was grievously ill. (2) The Paramedic concerned indicated that without the presence of the police to phyiscally coerce the patient, Paramedics within the Trust had been told that they should not become involved in physical coercion.

	(3) The Area Support Officer who gave evidence flatly contradicted the Paramedic and said that it was NOT Trust policy to act in this way and that Paramedics could and should (in appropriate cases) compel a patient in need to attend hospital
6	ACTION SHOULD BE TAKEN
1111 - 11	In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action; such action being to ensure that all Paramedics are fully aware of Trust Policy in dealing with mentally disordered patients and the provisions of the Mental Health Act and Mental Capacity Act.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 19 <sup>th</sup> November 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 Chief Coroner. I have also sent it to Mental Health Services Trust 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	Signed 92 JUL
	G U Williams 24th day of September 2014 H M Senior Coroner