**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br>**THIS REPORT IS BEING SENT TO:**<br>1. **The Secretary of State for Health**<br>2. **Chief Executive, Yorkshire Ambulance Service** |
| 1 | **CORONER**<br>Christopher Peter Dorries, senior coroner for the South Yorkshire (West) area. |
| 2 | **CORONER'S LEGAL POWERS**<br>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.<br>(1) Where –<br>(a) A senior coroner has been conducting an investigation under this Part<br>into a person's death<br>(b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and<br>(c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.<br>(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.<br>(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner |
| 3 | **INVESTIGATION and INQUEST**<br>On 19th April 2013 I commenced an investigation into the death of Anthony Offord (aged 35). The investigation concluded at the end of the inquest on 20 August 2014.<br>The narrative conclusion of the inquest was that *Mr Anthony Offord died at the Northern General Hospital, Sheffield on the 18th April 2013 in consequence of anoxia* |

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| | *sustained in an incident at Harcourt Road, Sheffield two days earlier, following the consumption of a small amount of morphine and a more significant amount of alcohol. An ambulance had been called at the time but the lone responder attending (who arrived nearby very quickly) felt the need to stand off until support was available on the grounds of personal safety. The double crewed vehicle nominated to back up the lone responder was some distance away.*<br>*There was a failure to consider other methods of support for the lone paramedic during that period but it cannot be said on the balance of probabilities that Mr Offord would have survived if any of the opportunities for alternative support had been taken.* |
| | **CIRCUMSTANCES OF THE DEATH** |
| 4 | Anthony Offord collapsed at a friend's flat on the edge of Sheffield city centre at approximately 23.00 on 16 April 2013. An ambulance call was made at 23.01 which was categorised as a 'Red 2'. At approximately 23.06 a lone responder (an Emergency Care practitioner or ECP) arrived near to the flat but for reasons of personal safety decided to stand off until supported.<br><br>The inquest did not seek to criticise or support the ECP's decision to stand off, it was made on a proper consideration of all known circumstances. One piece of information given to her by a colleague was ill-considered but the ECP would not have known this. The matters of concern in this report do not arise from the actual decision by the ECP but rather from the actions/inactions of those in the Operations Centre following that decision.<br><br>In making the decision to stand-off the ECP had enquired of the Emergency Operations Dispatcher (EOD) in the Operations Centre "*just wondering whether there was anyone else available to go with me*". There was no enquiry made as to exactly what was meant by this nor further discussion on the point. The ECP made clear in her evidence that in fact she would have been perfectly content to enter the premises with another lone responder or a single police officer.<br><br>A double crewed ambulance became available at 23.08 and was allocated to support the paramedic but this was on the outskirts of the city with an ETA of 23.24, that is a further 16 minutes delay. There was no thought within the Operations Centre as to alternative support for the ECP other than a double crewed ambulance, the lengthy delay was simply accepted without question.<br><br>Scrutiny at the request of the inquest revealed that there had been two other lone responders available in the area, both of whom would probably have reached the scene by 23.15. Reference to a further vehicle, albeit in rather different circumstances, is made at point 5(e) below.<br><br>Nor was any enquiry made of the police as to support. The city centre police station is within 1.5 miles of the scene and the city centre itself slightly closer. The evidence at the inquest made plain that requests to the police for assistance before entering are common and both paramedics who gave evidence said that in their experience they would be involved in such a situation about once a month.<br><br>Notwithstanding the evident delay in this Red 2 category call, the EOD did not involve a manager—and I understand that there was no protocol requiring her to do so. In fact Yorkshire Ambulance Service management did not learn of the stand-off or the delay in this case until the family of the deceased raised concerns with my office. |

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| | The double crewed ambulance arrived on scene at 2323 and entry was made within a minute or so thereafter. Mr Offord had by then sustained such a degree of anoxia that he died from his hypoxic brain injury two days later.<br><br>In fairness, it should be clear that despite careful analysis of expert evidence the inquest could not be satisfied on the balance of probabilities that Mr Offord would have survived if the alternative sources of support for the lone paramedic had been utilised. My concern in this report is for other cases in the future.<br><br>Finally, it should also be explained as a separate issue that throughout this time the Emergency Medical Dispatcher (EMD, in practice the call handler) remained on the telephone to those in the flat. The breathing diagnostic tool was used on more than one occasion and the recording of the call shows that at times Mr Offord's breathing (or grunting, gasping etc) was plainly audible. In fact the EMD asked at one point whether the noise he could he hear was Mr Offord breathing. On two occasions those in the flat make reference to Mr Offord snoring.<br><br>In evidence the EMD said that he had never received instruction on the various sounds of breathing, and was not aware that a snoring sound from a person who was unable to be roused was likely to indicate the potentially fatal obstruction of breathing. Nor was he aware that snoring is commonly a late sign in those whose unconscious state is caused by drug overdose. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) There is (apparently) no training given to Emergency Medical Dispatch staff as to signs of respiratory difficulty including the well known relevance of snoring in a person who cannot be roused. This may perhaps require an amendment to the breathing diagnostic tool?<br><br>(2) That where crew make a unilateral decision to stand off there is no requirement for a manager to be informed, even when there is likely to be a delay in the provision of support.<br><br>(3) That there is no system to ensure that all alternative methods of support are automatically considered when a stand-off occurs, not simply a double crewed ambulance.<br><br>(4) Consideration might be given as to whether drivers could be provided for lone responders on late shifts. This would be similar to the system used by many 'out of hours doctor' services and would provide some security for the lone responder thus lessening the need for stand-offs.<br><br>(5) With some diffidence, the point should also be raised that apart from the other lone responders who were available, as referred to in 'Circumstances of the Death' above, there was another double crewed ambulance nearby which could very likely have reached the scene as early as 2310 -- a point at which Mr Offord might have been saved. Unfortunately at 2302 this vehicle had become 'unavailable out of meal break window'. I recognise that this is a difficult subject, with valid arguments on both sides. I |

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| | appreciate that it is a national issue, much debated in the past, and I do no more here than record the position as regards that vehicle. |
| 6 | **ACTION SHOULD BE TAKEN**<br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 9 November 2014. I, the coroner, may extend the period.<br>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**<br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br>• the family of Anthony Offord<br><br>I have also sent it to the following who may find it useful or of interest:<br>• The Care Quality Commission<br>• The Association of Ambulance Chief Executives, London SE1 9EU<br>• International Academies of Emergency Dispatch, Bristol BS1 3LG<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **8 September 2014** ***Christopher P. Dorries*** |