Regulation 28: Prevention of Future Deaths report

Yusuf ABDISMAD (died 02.01.15)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **London Central & West Unscheduled Care Collaborative** **(LCW UCC - NHS 111 service provider)** **St Charles Hospital** **Exmoor Street** **London W10 6DZ**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 5 January 2015, I commenced an investigation into the death of Yusuf Abdismad, aged 5 years. The investigation concluded at the end of the inquest on 19 May 2015. I made a determination of death by natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Yusuf died from meningococcal septicaemia. His mother called 999 at 10.42am on 2 January 2015. Following assessment by the emergency medical despatcher, she was advised to call 111. She did so and then at some point during that call, the 111 service called 999 again. By the time the London Ambulance Service arrived, Yusuf was in cardiac arrest.

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. During the 111 call, Yusuf's mother said at one point that Yusuf was not breathing. Rather than responding to this as a red flag that required immediate paramedic attendance and asking for London Ambulance Service to be notified, the LCW call handler felt she wanted to probe further. Evidence in court from the 111 service was that call handlers would benefit from further training in recognising agonal breathing. I appreciate that 111 is not intended as an emergency service, but they are likely from time to time to take calls that are or become urgent.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and 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 27 July 2015. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Professor Dame Sally Davies, Chief Medical Officer for England • NHS England • [redacted] Yusuf's mother

	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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 27.05.15