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. Ken Wenman, Chief Executive** **South Western Ambulance Service**
1	**CORONER** I am M. E. Voisin, Senior Coroner, for the Area of Avon
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 16th January 2015 I commenced an investigation into the death of **Michael Lawrence HACKER,** Aged **66**. The investigation concluded at the end of the inquest on 6th May 2015. The conclusion of the inquest was **Natural Causes** with the medical cause of death being Ia) Gangrene of the foot and 1b) Type 2 diabetes mellitus
4	**CIRCUMSTANCES OF THE DEATH** Mr. Hacker was an eccentric man who refused hospital admission to treat his gangrene. He was assessed as lacking capacity to refuse admission on 19th December but died on 28th December 2014 at his home address before hospital admission
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. [redacted] an Advocacy and Locum Consultant IMCA expressed in evidence his concerns in relation to the ambulance service in this particular case. I heard evidence that South West Ambulance Services Trust had attended Mr. Hacker previously to take him to hospital for treatment of his gangrene and had not been successful in persuading Mr. Hacker to go with them. [redacted] contacted [redacted] from the South Western Ambulance Services Trust before and after Mr. Hacker's death to be told that if an ambulance turned up at the property then there was a protocol in place that meant that the crew would not use restraint or apply force if Mr. Hacker did not want to go with them. [redacted] expressed concerns as to the Trust's policy around the Mental Capacity Act. If Mr. Hacker had been taken to hospital sooner he may or may not have received treatment depending on a number of factors including his capacity to make decisions. I did not make any criticism around the ambulance service in this case however it did raise a concern with me about prevention of future deaths. I am therefore writing this report to ask that you consider your training and policy around the Mental Capacity Act

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 Monday 6th July. 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 Interested Persons at the inquest. 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	**08 May 2015** **M. E. Voisin** [redacted]