Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 the 14th February 2013 I opened an inquest touching the death of Paul Alexander Murray , 47 years old. The inquest concluded on the 25h February 2015. The conclusion of the inquest was "Narrative", the medical case of death was 1a Fatal cardiac dysrhythmia 1b Myocarditis.
4	**CIRCUMSTANCES OF THE DEATH** Paul Alexander Murray died from the results of a myocarditis on the 8th February 2015 that was likely to have begun a day or so before. Mr Murray began to show symptoms and the first call was made to the London Ambulance Service at 12.00 . There are three matters that are likely to have a bearing on Mr Murray's death Firstly that Mr Murray was developing the symptoms of a myocarditis such that he was vomiting and in some pain at the time of the first call to the London Ambulance Service. The Ambulance Service would not have been able to associate the general symptoms with a myocarditis. Secondly there were insufficient ambulances in circulation to respond following the second call at 12.19 if there had been sufficient ambulances and an ambulance had attended to Mr Murray it is likely that he would not have had the cardiac arrest as it is likely that had treatment been provided by the ambulance staff that treatment would have delayed the onset of Mr Murrays cardiac arrest.

	Thirdly that had Mr Murray been taken to hospital following the call at 12.19 arriving there before his cardiac arrest it is likely that he would not have died when he did. Mr Murray did receive an emergency response by a first responder after a 4th call saying that Mr Murray had become unresponsive, a criteria that generates an emergency response. Mr Murray was taken to hospital arriving at 14:50 pm where despite treatment he 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. – That there were insufficient resources available for the London Ambulance service to meet the demand on the 8th February 2013 at 12.19
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 Wednesday 8th 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 Chief Coroner and to the following Interested Persons;- Representatives of the family. London Ambulance Service 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	13th M[redacted]