Regulation 28: Prevention of Future Deaths report

Lisa Margaret DAY (died 12.09.15)

	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** **2. Dr Fionna Moore** **Chief Executive** **London Ambulance Service NHS Trust** **220 Waterloo Road** **London SE1 8SD**
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 22 September 2015, I commenced an investigation into the death of Lisa Margaret Day, aged 27 years. The investigation concluded at the end of the inquest on 15 February 2016. I made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH**

	Ms Day's medical cause of death was: 1a cardiac arrhythmia from hyperkalemia 1b diabetic ketoacidosis 1c poorly controlled type I diabetes An ambulance reached her approximately four and a half hours after one was first called. She was taken to hospital, but by that stage her condition was irretrievable.
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. When Ms Day's friend rang the 111 service on her behalf, the possibility of conveying her to hospital by means other than an ambulance was discussed with her and she declined. However, it was not discussed with her friend who made the call. He would have been much better placed to organise this and, if he had, it would probably have resulted in life saving hospital treatment. The potentially very grave consequences of a vomiting illness in a person with diabetes were not explained to him. 2. I heard at inquest that the 111 and 999 services have begun a process to promote more effective communication of 111 concerns to the London Ambulance Service in situations like this. It seems that this would be of great benefit to patients.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 25 April 2016. 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 • Care Quality Commission for England • Professor Dame Sally Davies, Chief Medical Officer for England • Association of Ambulance Chief Executives (AACE) • National Ambulance Service Medical Directors (NASMeD) • [redacted], parents of Lisa Day 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** 23.02.16