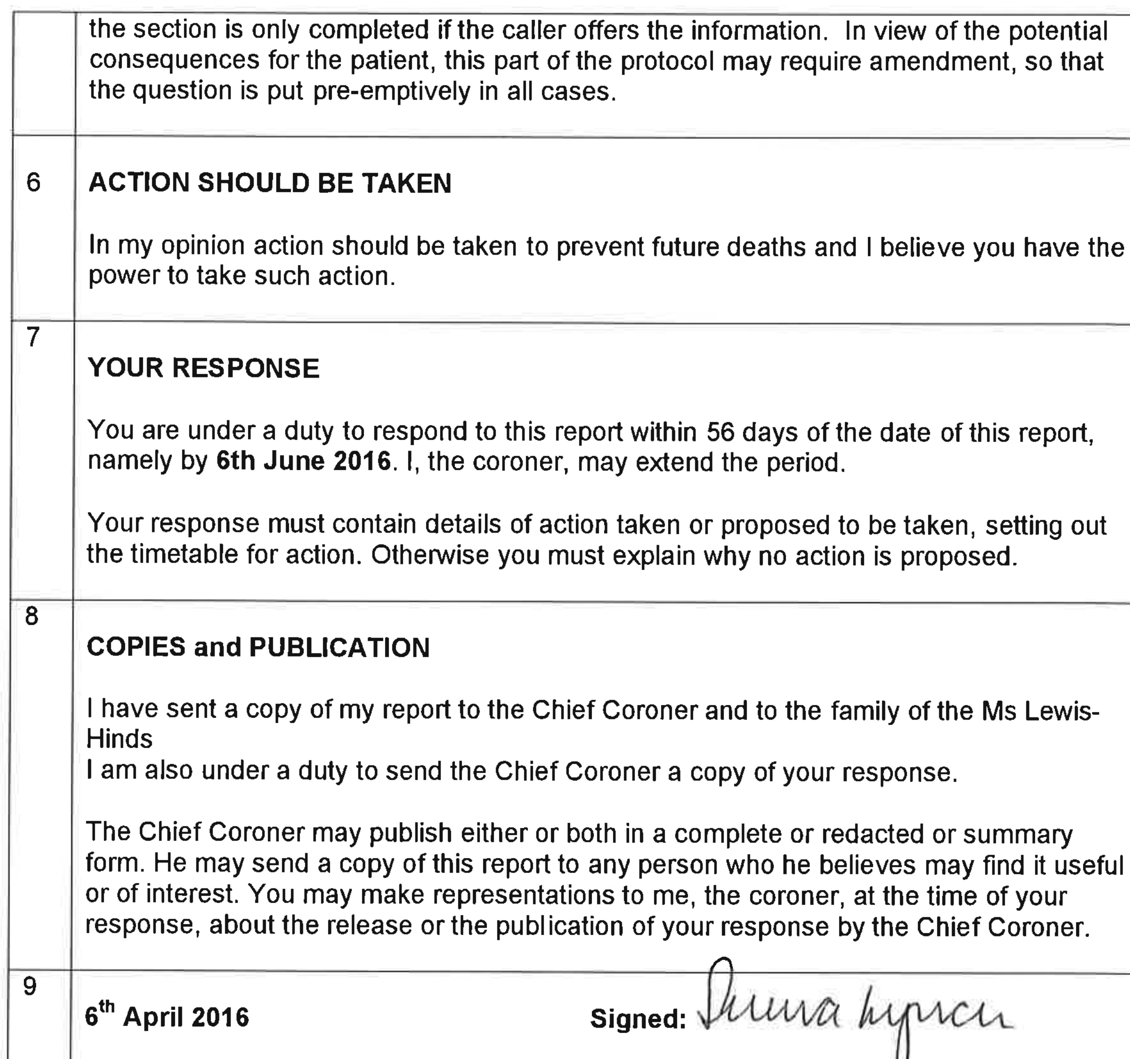
In the South London Coroner's Court

Inquest touching the death of Monica Elaine Lewis-Hinds

Report to Prevent Future Deaths (*Coroners (Investigations) Regulation 28)*

	THIS REPORT IS BEING SENT TO: **Dr Fionna Moore MBE, Chief Executive, London Ambulance Service**
1	**CORONER** I am Selena Lynch senior coroner for the coroner area of South 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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 26th January 2015 I commenced an investigation into the death of Monica Elaine Lewis-Hinds. The investigation concluded at the end of the inquest on 11th February 2016. The medical cause of death was asphyxia due to epileptic seizure. The conclusion of the inquest was a narrative conclusion: that Ms Lewis Hinds suffered a seizure at home some time after midnight on 16th January 2015. An ambulance was requested at 0028 whilst she was in a distressed post-ictal phase. She suffered a further seizure some time after 0128 which led to asphyxia, cardiac arrest, and death.
4	**CIRCUMSTANCES OF THE DEATH** Ms Lewis-Hinds suffered from poorly controlled epilepsy. An ambulance was requested to attend her home just after midnight on 16th January 2015 as she had suffered a seizure. The seizure was atypical, something which raises the priority of the call to Red 2 (response time of 8 minutes). The type of seizure was not ascertained by the call handler, resulting in a delayed response. It was not possible to ascertain whether the delay caused or contributed to the fatal outcome.
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. – The protocol used by the London Ambulance Service to triage calls includes a question about the type of fit, but the question is not posed by the call handler to the caller, and



	the section is only completed if the caller offers the information. In view of the potential consequences for the patient, this part of the protocol may require amendment, so that the question is put pre-emptively in all cases.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by **6th June 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 Chief Coroner and to the family of the Ms Lewis-Hinds 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	**6th April 2016** **Signed:**