REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **North East Ambulance Service NHS Foundation Trust**
1	**CORONER** I am Clare Bailey, acting senior coroner, for the coroner area of Teesside.
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 5 November 2015 I commenced an investigation into the death of Mandeep SINGH age 36 years. The investigation concluded at the end of the inquest on 18 March 2016. The conclusion of the inquest was MISADVENTURE with a medical cause of death of Ia) Alcohol Toxicity and II Hypertensive Heart Disease.
4	**CIRCUMSTANCES OF THE DEATH** Mr Singh had consumed high levels of alcohol during the day on 2 November 2015. At approximately 11.45pm his wife went to bed leaving him watching television downstairs. At approximately midnight she went to check on him and found him lying on the floor. He was breathing but unconscious. She rang the ambulance services. Despite assessing the call as a R1, with a target response time of 8 minutes it took 27 minutes for the ambulance to arrive. Mr Singh died whilst in the ambulance.
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. – A root cause analysis comprehensive and independent investigation report undertaken by the North East Ambulance Service discloses that the reasons for the delay of the ambulance arrival include severe demand and shortages in the division. Road closures and diversions did not assist the crews.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 18 May 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 following Interested Persons, [redacted], Mr Mandeep's wife. 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	**DATE** 23.3.16 **SIGNED BY CORONER** Mandeep