REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive,** **Tunstall Response,** **Ascot House,** **Malton Way,** **Adwick le Street,** **Doncaster.** **DN6 7FE.**
1	**CORONER** I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West 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** On the 17th July 2015 an investigation was opened touching the death of Patricia Mercieca, who died aged 60 years on the 14th July 2015 at Flat 34, Charlwood House, Vauxhall Bridge Road, London. SW1V 2SY. The inquest was concluded on the 12th July 2016 at Westminster Coroner's Court. The following findings and determinations were made**:** The **medical cause of death** was recorded as: 1(a) *Chronic Obstructive Pulmonary Disease and Asthma and Methadone Intoxication.* **How, when and where and in what circumstances** the deceased came by her death: Patricia had a long standing history of drug dependence, severe COPD and asthma and was resident in assisted living accommodation. On the 14/7/2015 she pulled the emergency cord at her address at approximately 21:00 and informed the call handler that she could not breathe. She arrested shortly after this such that on the arrival of the LAS at approximately 22:15 she was found to be deceased. **Conclusion** of the Coroner as to the death: ***Natural Causes and Drug Dependence***
4	**CIRCUMSTANCES OF THE DEATH** Evidence taken at the inquest was that the call handler called the LAS to request an ambulance however did not give correct information to the LAS such that the call could be correctly prioritised. The LAS clearly on two occasions advised the call handler to recheck whether Ms Mercieca could talk without becoming short of breath which if she could not would have upgraded the call priority. The call handler did not do this. In fact when the call handler re contacted Ms Mercieca to let her know an ambulance was on

	the way, she did not respond to him at all. He did not pass this information onto the LAS, and also did not, in contravention of the agreement between Tunstall Response and Westminster, contact the manager of the supported housing in which Ms Mercieca was resident. The evidence was that if he had so done, that manager was at home in the same accommodation block and would have immediately attended Ms Mercieca' s flat to give any appropriate assistance. On consideration of the evidence since it was not known when Ms Mercieca arrested, it could not be said on the balance of probabilities that had the call been appropriately handled she would have survived and so the failures could not be said to be causative in her death. The evidence was that the call handler was acting in line with company procedures when he did not follow up with Ms Mercieca as requested by the LAS. Further not all authorities with which Tunstall are contracted to respond to handle calls require that their managers are contacted when a resident contacts Tunstall in an emergency. I understand that Tunstall handle approximately two million calls per annum, of which approximately 10% are medical emergencies. Most authorities with which they contract do not have resident managers in their supported housing schemes. The evidence was also that the medical history of Ms Mercieca was not recorded on the computer screen available to the call handler and so could not be passed to the LAS. This information would have also upgraded the call. I understand that audit procedures are in place to address this matter.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – (1) That the call handlers need to be refresher trained in relation to contacting resident managers for Westminster residents following a medical emergency call. (2) That wherever there is a person contacting them in an emergency where there is a manager, that manager should be contacted whatever authority covers the person contacting the call handler. (3) That if a call handler is directed by emergency services such as the LAS, or other relevant professionals such as a doctor to obtain further information or reassess then they should do so and pass any information so gained back to the agency or professional that requested it. (4) That call handlers be trained such that if they get no response when contacting a person who has contacted them and that person is a user of the emergency call system, then immediate concerns should be raised with the appropriate agencies for example the LAS and resident scheme manger.
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. It is for each addressee

	to identify the concerns relevant to their own areas of responsibility.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13th September 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] [redacted] [redacted] c/o Edmund Conybeare, Legal Studio Solicitors, The Tannery, 91 Kirkland Road, Leeds. LS3 1HS. [redacted] Operations Manager, Tunstall Response, Ascot House, Malton Way, Adwick le Street, Doncaster. DN6 7FE. [redacted] Head of Provided Services, Westminster City Council, Westminster City hall, 64, Victoria Street, London. SW1E 6QP. I have also sent a copy to the LAS: [redacted] Head of Quality Assurance, London Ambulance Service, 220 Waterloo Road, London. SE1 8SD. 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	**19th July 2016.**  **Dr Fiona Wilcox,** **HM Senior Coroner,** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED.**