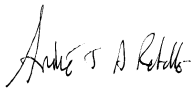
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Magenta Living Support Link** **Partnership Building** **Hamilton Street** **Birkenhead** **CH41 5AA**
1	**CORONER** I am André Joseph Anthony Rebello, Senior Coroner, for the area of Liverpool & Wirral
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 13th November 2015 I commenced an investigation into the death of **Ronald VOLANTE**, Aged **74**. The investigation concluded at the end of the inquest on 28th January 2016. The conclusion of the inquest was Ia Ischaemic Heart Disease Ronald Volante has died of Natural Causes it is not possible from the evidence to say that there was an opportunity to have prevented his death
4	**CIRCUMSTANCES OF THE DEATH** Ronald Volante suffered from coronary artery disease which has caused ischaemic heart disease and an enlarged heart. He had previously suffered a myocardial infarction which required triple vessel coronary artery bypass grafting. Ronald Volante was in difficulty at 18.35 on 5th November 2015 and called an out of hours alarm monitoring service shouting for help. The monitoring service are not contracted to respond in person within this sheltered accommodation tenancy agreement. The monitoring service made attempts to contact Mr Volante's next of kin. An ambulance was called at 18.38 and from the information given the call was coded as green 2 for an ambulance to be dispatch as soon as possible. This was a busy bonfire night and was coded green 2 because Mr Volante was breathing and conscious. The ambulance were not given information from Mr Volante's medical notes nor were they alerted that by the time the call between he monitoring service and Mr Volante finished at 18.46, Mr Volante was no longer responding to information that an ambulance had been called - this was a change in circumstances as there was no longer evidence that Mr Volante was conscious and breathing. The ambulance arrived at 20.28 and Mr Volante was already deceased being certified at 20.29. It is found that Mr Volante died at some time between 18.35 and 20.29.

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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Magenta Living Support Link had access to Mr Volante's medical history and there is no evidence that this was used to advise the ambulance service of his cardiac problems – is this covered in the induction training of call handlers? (2) Magenta Living Support Link were aware that there had been a change in Mr Volante's presentation by 18.46 as he did not respond to the news that an ambulance was on the way – is this covered in induction training of call handlers with regard to advising a doctor or emergency service of a change in circumstances after the first call? (3) The training manual and method of training call handlers needs to be revisited in the light of the experience from Mr Volante's tragic death (4)
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 24th March 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] – Daughter [redacted] – Daughter North West Ambulance Service Regenda Housing who may find it useful or of interest. 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool and Wirral** **Dated: 28th January 2016**