REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Alex Whitfield, Chief Executive, Royal Hampshire County Hospital Romsey Road, Winchester, Hampshire SO22 5DG 2. Will Hancock, Chief Executive, South Central Ambulance Service NHS Foundation Trust, North Wing, Southern House, Sparrowgrove, Otterbourne, Hampshire SO21 2RU
1	**CORONER** I am Karen Harrold, Assistant Coroner for the coroner area of Central Hampshire.
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/ukpga/2009/25/schedule/5 http://www.legislation.gov.uk/uksi/2013/1629/made
3	**INVESTIGATION and INQUEST** On 27th March 2017 the Senior Coroner, Grahame Short, commenced an investigation into the death of Mark William Berry, aged 47 years old. The investigation concluded at the end of the inquest on 29 June 2017. I recorded a conclusion of Drug Related Death and the medical cause of death as: 1a) Morphine toxicity.
4	**CIRCUMSTANCES OF THE DEATH** An ambulance was called at 23:39 on 29th April 2017 to Flat 3 at 68 Stockbridge Road, Winchester due to Mark Berry being in cardiac arrest. It arrived at 23:48 and Mr Berry was taken to the Royal Hampshire County Hospital (RHCH) after paramedics managed to get a pulse arriving there at 00:53. Despite treatment, Mr Berry was declared dead at 01:32. After police enquiries, they eventually obtained the address where the ambulance staff had treated Mr Berry. Further officers attended Flat 3 at 68 Stockbridge Road at 06:45 and managed to rouse the male occupant and his girlfriend who lived there. It was ascertained that with friends, Mr Berry, appeared to have taken a mixture of prescription and illegal drugs thought to be pregabalin and heroin the prevous evening following which they all went to Flat 3. The occupants of the flat fell asleep and later found Mr Berry in the room and became concerned as he was unresponsive and thought he was not breathing. The male occupant started CPR until ambulance staff arrived at approximately 23:00. Toxicology analysis reported that 0.16mg/L of morphine was detected in Mr Berry's blood. As the therapeutic concentrations in plasma is usually in the range of 0.01-0.07 mg/L, the level found in Mr Berry fell within the levels associated with therapy and fatalities. Pregabalin was also found in blood but this was within therapeutic range. However, the pathologist concluded that both of these drugs are respiratory depressants and the combination of toxic levels of morphine with the pregabalin may have led to

	respiratory depression, coma and death. In addition, the presence of vegetable matter in the airways possibly represented aspiration of food or vomit which could also further compress depressed respiratory functions. In conclusion, the pathologist gave cause of death as Morphine Toxicity.
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. – I heard evidence at inquest from [redacted] and also had sight of a statement from [redacted] of Hampshire police that he attended RHCH at 05:55 after hospital staff contacted police to report the sudden death of Mr Berry. The officer queried with the sister in charge, [redacted] why there had been such a delay (over 4 hours since death) in notifying police about the death. The officer was told that there had been some confusion about the correct procedure to contact police. It was known that Mr Berry was a heroin user and it had been suspected that he had consumed heroin prior to his death. It was noted that there were two small puncture wounds on Mr Berry's right forearm only one of which was caused by ambulance staff during treatment. [redacted] confirmed that hospital staff did not have the details of the address where Mr Berry was found so this necessitated [redacted] in having to make further enquiries to try and locate the ambulance staff. [redacted] managed to locate an ambulance technician, [redacted], who was part of the second ambulance crew to arrive at [redacted] but the first attender, [redacted] had by then gone off duty. I was also told that when SCAS control room was contacted for the exact details, police were told that a private ambulance attended. PC Headen attended [redacted] at 06:45 but it again took some time to discover the exact address as the building is multi-occupancy. It was therefore some 6 hours+ after death was confirmed that the officers were able to locate and speak to the occupants of the flat who found Mr Berry. On the evidence I heard, it seemed clear that the occupants were themselves under the influence of drugs. My concerns are: 1. Hospital staff did not contact police in what appeared to be a suspicious and unnatural death for several hours. Further, I was told there appeared to be confusion about the correct procedure with regards to notifying police. This suggests a possible need to revisit who, when and how hospital staff contact the police both before and after death in appropriate cases. 2. Although I was not shown the handover paperwork from the ambulance technicians to hospital staff, the lack of basic detail such as the address where Mr Berry was found may mean that handover procedures should be revisited especially if there is a private ambulance service involved. 3. Finally, the lack of an address may require further consideration of how basic but potentially important data is conveyed to SCAS control room from a private ambulance service especially before staff go off duty and thereby avoiding delay.
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 5th September 2017. 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 I am also under a duty to send the Chief Coroner a copy of your responses. 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: 11th July 2017** Karen Harrold Karen Harrold Assistant Coroner Central Hampshire