REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NWAS
1	**CORONER** I am Julie Robertson, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 11 May 2017 I commenced an investigation into the death of **David Michael Lee**. I concluded this inquest on 21 June 2017 and found that there was a missed opportunity to escalate the deceased's call to 999 by NWAS. I also found that NWAS should not have terminated the deceased's call because in between the call ending and the ambulance attending at the deceased's home address the deceased became unconscious and died.
4	**CIRCUMSTANCES OF DEATH** The deceased was found unresponsive at his home address on 18 February 2017 and fact of death was confirmed by paramedics when they arrived. An ambulance was called by the deceased at 6 am but did not arrive at the deceased's address until 7:23 am. The deceased's call with 999 was terminated by NWAS approximately 30 minutes into the call to enable to call handler to attend to other calls. However, after the call ended the deceased became unconscious and life was extinct prior to the arrival of NWAS. In terminating the call there was a missed opportunity to escalate the response that the deceased requmired. The deceased died from the consequences of diphenhydramine toxicity and had taken a considerable quantity of this drug just prior to death. He made this known to NWAS during his 999 call and the NWAS call handler was aware that the deceased was alone and that he, therefore, would not be able to call back if he became unresponsive and if his condition worsened, which subsequently happened.
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:- That the call was inappropriately terminated and that this may continue in the future. That there was a missed opportunity to escalate the urgency of the requirement for medical assistance due to the call being terminated.

	Since the call guidance has not been circulated to members of call handling staff regarding in what circumstances it is appropriate to terminate call and when a call handler should, as a matter of best practice, remain on the line with the patient. Such guidance was circulated twice prior to the deceased's death but was not adhered to on this occasion. That there has been no training given to staff since the deceased's death to address when it is appropriate to terminate calls with patients.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 23 August 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 to the following Interested Persons namely:- The family of the deceased. 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 from. He may send a copy of this report to any person who he believes may find it usefulor 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: 28 June 2017 Signed: