

## SIGNED BY TITLE JURISDICTION

Geoffrey Sullivan Senior Coroner Hertfordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
:	THIS REPORT IS BEING SENT TO: East of England Ambulance Service, Lister Hospital, Luton & Dunstable Hospital, Princess Alexandra Hospital
	CORONER
	I am Geoffrey Sullivan Senior Coroner for Hertfordshire
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/paragraph/7  http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On the 6 <sup>th</sup> June 2017 I commenced an investigation into the death of Matthew Luke FAULKNER, age 36yrs. The investigation concluded at the end of the inquest on 27th March 2018. The conclusion of the inquest was <b>Alcohol Related</b> .
	Medical Cause of death:  1a. Ligature Suspension
4	CIRCUMSTANCES OF THE DEATH  On the evening of the 30th May 2017 Matthew Faulkner was found hanging from the door handle of his bathroom by paramedics. He was hanging by the collar of his tracksuit which was zipped up to the neck. He was confirmed dead at 21:57hrs. He had struggled for many years with mental health problems and excess alcohol consumption.
	Whilst the evidence did not support a finding that the delay of the East of England Ambulance Service (EEAS) attendance contributed to Mr Faulkner's death, the time taken to attend his home after an emergency call had been received by the EEAS is a cause for concern. The 999 call was initially graded Green 1, with an expected attendance in 20 minutes; this was then downgraded to a Green 2 with an expected attendance in 30 minutes. The call was made at 16:44hrs, an ambulance attended at 21:41hrs, almost five hours later.
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) At the time of this incident, demand on the EEAS far outstripped the resources available to them.

- (2) That the current position regarding demand outstripping available resources is not significantly different to that in May 2017.
- (3) That the demands placed on the EEAS by the public are not sustainable. With, in the region of, only 60% of ambulance attendances resulting in admission to hospital for urgent care.
- (4) That there are still significant delays on hand-over to hospital, exacerbating the lack of Ambulances being available to answer emergency calls.

## 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 30<sup>th</sup> May 2018. 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:

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 29/03/2018

Signature Geoffrey Sullivan Senior Coroner Hertfordshire