REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1 [redacted] Senior Quality Assurance Manager Control Services London Ambulance Service NHS Trust 220 Waterloo Road London SE1 8SD 2. [redacted] Legal & Governance Service London Ambulance Service NHS Trust 220 Waterloo Road London SE1 8SD
1	**CORONER** I am Russell Caller Assistant 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 AND INQUEST** **On 5th February 2018 I opened an investigation into the death of Olive Nutt. The investigation concluded at the end of the Inquest on 26th June 2018. The medical cause of death was Natural Causes.**
4	CIRCUMSTANCES OF THE DEATH The deceased died on 29th January 2018 at her home at [redacted] Westminster from heart disease. However, in the lead up to this death the deceased had to wait a period of up to 5 hours before a member of the LAS attended her home by which time the deceased was already dead.
5	**Coroners Concerns:** The **MATTERS OF CONCERN** are as follows. – 1) The LAS failed to make a relevant and proper note of the symptoms of the deceased when these were phoned through to the LAS and as a result the clinicians at LAS made an incorrect priority decision which caused significant delay in a timely attendance being made on the deceased 2) The LAS breached its own pre-set time guidelines in failing to return a call to the deceased's home to take further details of her medical conditions.
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 8th October 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 person(s): [redacted] [redacted] 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	**12th June 2018**  **Russell Caller** **HM Assistant Coroner,** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED.**