REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Head of Highways Infrastructure, Leeds City Council, Middleton Complex, Middleton Ring Road, Leeds, LS10 4AX**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 18 May 2017 an Investigation was commenced into the death of Joshua Lee Edwards, aged 19. The Investigation concluded at the end of the Inquest on 1st October 2018. The conclusion of the Inquest was a drug-related death in which the cause of death was 1(a) Hyperthermia, Metabolic Acidosis, Disseminated Intravascular Coagulation and Cardiac Dysfunction 1(b) Methylenedioxy-Methamphetamine and Cocaine Use.
4	**CIRCUMSTANCES OF THE DEATH** Joshua Lee Edwards aged 19 was observed to be acting in a bizarre fashion around midday on Sunday 14th May 2017 in Leeds. The Police were called and found him on the ground under a parked car thrashing his limbs. An ambulance was called at 1219 hours but did not arrive until 1244 hours. He was taken to Hospital but despite maximal treatment deteriorated and died on 15th May 2017 at 0905 hours at St James's University Hospital, Leeds. Toxicology analysis revealed he had taken ecstasy and cocaine.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. – (1) The ambulance despatched to the scene encountered roads closed for the Leeds 10K run that day. It then navigated a route around the course, thus encountering a delay in reaching the casualty. The Police Officers at the scene telephoned three times to ask where the ambulance was but this did not result in the situation being escalated in the control room at Yorkshire Ambulance Service.

	(2) Evidence taken at the Inquest indicated that ambulance crews were unclear as to whether they were entitled to cross 'road closure' signs in an emergency. Clarification of the Ambulance Service authority to do so in an emergency has been given, but has not yet been circulated to all ambulance crews. This needs to be done on the morning of such events. Ambulance crews should be reminded of this power by way of a refresher briefing. Similar considerations arise in relation to the Fire and Rescue Service. (3) In the preparation for such public events, the organisers should be required to brief their Marshalls that at specified crossing points, the event may require to be halted momentarily to allow emergency response vehicles to cross. In short, that an emergency may take precedence. Participants in the event should also be forewarned of the possibility of this occurring. (4) Road closure signs at such designated crossing points should be replaced by signs indicating 'Access to emergency vehicles only' or equivalent wording.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 5th December 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 have also sent it to [redacted] (parents of the deceased), Mr Tom Riordan (Chief Executive, Leeds City Council), [redacted] (Head of Highways Department, Leeds City Council), [redacted] West Yorkshire Police), [redacted] (West Yorkshire Fire and Rescue Service), Ms Rachel Reeves MP, [redacted] (The Yorkshire Post) and [redacted] (Yorkshire Evening Post) 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	**2nd October 2018** Kevin McLoughlin **KEVIN McLOUGHLIN** **Senior Coroner**