REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Chief Executive, Joint Royal Colleges Ambulance Liaison Committee (JRCALC)
1	**CORONER** I am Ms L Hashmi, Area 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 8th January 2019 I commenced an inquest into the death of Gareth Cecil Bickerstaff.
4	**CIRCUMSTANCES OF DEATH** Against a backdrop of long term illicit substance and alcohol misuse, depression, and personal tragedy at a young age, in the months leading up to his death the deceased had started to exhibit increasingly frequent episodes of paranoia and associated erratic and sometimes dangerous behaviour. This brought him into contact with mental health RAID teams on three separate occasions between January and May 2018. Assessments were conducted and support offered but declined. On the 20th May 2018, the deceased entered a local Tesco Express supermarket. At the material time he was experiencing paranoia whilst under the influence of drugs and alcohol. He became increasingly agitated and scared. Having climbed across and then on to the check-out counter he began to damage the suspended ceiling, thereafter entering the roof space. The shop was evacuated and the doors locked pending police arrival. Police attended on a category 1 response, with the first officer on scene at around 22:24. Further officers arrived shortly thereafter. At the point the deceased was seen to place a wire ligature around his neck, the first police officer and the deceased's brother entered the store and tried to engage with him, to no avail. He subsequently removed the ligature and continued to move around the roof space. At around 22:40 the deceased went quiet and on closer inspection was noted to have self-ligatured on a main roof suspension cable. Police attempted to gain access to the roof space but their efforts proved futile. Contact with the ambulance service was initially made at around 22:33 however a further call was logged at 22:39. At was at this point the call to the ambulance service was regraded to a category 1 response as the deceased had self-ligatured. Paramedics were in attendance by 22:43. The Fire and Rescue Service was not called to attend until 22:44, despite their rescue capabilities. They arrived on scene at 22:47. Extrication of the deceased was achieved shortly after 23:00. The fact of the deceased's death was confirmed by paramedics at 23:06 at the Tesco Express Store, Ashton Road, Oldham. Cause of Death: 1a) Hanging

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:- 1. During the course of the evidence heard at inquest, it became apparent that there was a critical difference between the language used within the JRCALC Guidance and the local ambulance Trust's guidance to Paramedics in relation to the diagnosis of death/decision to resuscitate criteria. I was told that whilst Trusts base the drafting of local Guidance/Policy on the JCALC Guidance, they are permitted to use their own language/interpretations. The JCALC Guidance indicates that resuscitation should not be attempted [*inter alia*] where more than 15 minutes have passed since the *onset of cardiac arrest* (presumably diagnosed clinically and/or by way of ECG), whereas the local ambulance Trust's guidance indicates that the 15 minute timeframe should be calculated from the *onset of 'collapse'* (this is not defined further but *prima facie* is reliant upon bystander observation). I am concerned that in allowing for 'local interpretation' and different meanings as to when the 15 minutes is calculated from, there is the potential for misinterpretation, ambiguity and misunderstanding in relation to emergency resuscitation, creating a risk of future deaths.
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 by the 22nd March 2019. 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 deceased's family - NWAS - GMP - Pennine Care NHS Foundation Trust - DoH - College of Paramedics - Health and Care Professions Council 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 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: 25th January 2019 Signed: