REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dorothy Hossein, Interim Chief Executive, trust Headquarters, Melbourne Ambulance Station, Whiting Way, Melbourn, Cambridgeshire SG8 6NA** **2. [redacted], Emergency Operation Centre, Norwich**
1	**CORONER** I am Jacqueline Devonish, area coroner, for the coroner area of Suffolk
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 7 January 2019 I commenced an investigation into the death of Mark Harris, aged 24. The investigation concluded at the end of the inquest on 16 January 2019. The conclusion of the inquest was that the death was a misadventure with a medical cause of death of asphyxia due to hanging contributed to by his mental health, the communication of bad news by his AFCASS Officer that morning, the volatile relationship with his ex and the communication failure between the ambulance service and police, and between the police control room and attending officers.
4	**CIRCUMSTANCES OF THE DEATH** On 11 January 2016 Mark Harris was found deceased with a rope around his neck at the home of his ex-partner where he was residing at the time. Mr Harris had been taken into police custody between 8 & 10 January 2016 for amongst other things common assault against his ex-partner and breach of bail conditions to attend her property. Upon his release he went home to his ex-partners address where he was living alone, with her agreement. He messaged his ex that evening and threatened to kill himself if he could not be with her. He had a history of self-harm and was well known to the police. When nothing was heard from him the following day his ex called 999 for a welfare check at about 1.40pm. The ambulance service requested the attendance of police when the ex-partner indicated that he could be violent. The ambulance service graded the call for attendance within 30 minutes. The police initially attended around 2.30pm leaving at 3.10pm, and then again after 5pm. They requested additional information from the ambulance service and their own control room to identify the occupant of the property. They were unaware that the ex-partner had said he was definitely in the property and unaware that she had a key and was only 30 minutes away. Neither were they made aware of the recent custody or the conditions of bail when they told the control room that they suspected it was Mark Harris and not Hais. The ambulance service first attended at 4.38pm due to the heavy demands on the service that day, but there was a further delay in gaining access to the property until the ex-partner attended with the key around 5.10pm. Mr Harris was found to have ligatured. The ambulance service recognised life as extinct immediately. The police believed that they had been asked to conduct a welfare check on a Mr Hais.

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 could 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 999 call was directed to the ambulance service for a welfare check. The suicide protocol was initiated by the call handler took key information. When the police were called the mis-spelt name of the deceased as HAIS was provided to them together with detail of the nature of the welfare call as 'messaging all night threatening to kill himself'. The police attended the address. Had the correct spelling of the name been provided to the police they would have known Mark Harris and his history of suicide attempts. This was a significant problem for an intelligence led service. (2) It was unclear to the police that they were being asked to attend to safeguard ambulance personnel and not to undertake a welfare check. The protocol used by the call handler did not make provision for that to be stated. (3) The police evidence was that in the event of a welfare call, which they could conduct in any event under section 17 powers in the absence of the ambulance service, there was additional information that should be shared including the name and contact telephone number of the informant, and the information recorded in the ambulance service CAD. (4) There is no agreed protocol between the ambulance and police services facilitating communication to formulate an ambulance service protocol which incorporates information helpful to the police.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 18 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 [redacted] and [redacted] I have also sent it to [redacted] 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	**17 January 2019**