## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>[redacted]<br>**Executive Chair**<br>**JRCALC**<br>**32 Southwalk Bridge Road**<br>**London**<br>**SE1 9EU** |
| 1 | **CORONER**<br><br>I am Lydia Charlotte Brown Assistant Coroner, for the area of Leicester City and Leicestershire South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 24 April 2018 I commenced an investigation into the death of George Graham Smith<br><br>The Inquest concluded on 21st May 2019<br><br>Cause of death:<br><br>Carbon monoxide poisoning as a result of a fire |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Smith died in a house fire at his home address, [redacted] Leicestershire on 24th April 2018.<br><br>**Narrative conclusion**<br><br>Mr Smith had a history of drinking excess alcohol and taking unregulated and non-prescribed benzodiazepine medication he purchased over the internet. He required hospital treatment during 20th – 21st April 2018 when withdrawing from both alcohol and benzodiazepines and was then discharged home.<br><br>His condition started to deteriorate over the following days, and three separate calls were made for ambulance assistance, but on all occasions he refused to be transported back to hospital, against the advice of the attending crews and on the final occasion, also against the advice of his general practitioner. The crews had insufficient training or back-up resource material regarding alcohol withdrawal symptoms and were therefore unable to give full appropriate information to Mr Smith, or assess his capacity fully. It is possible if this information had been available this would have led to Mr Smith being taken to hospital earlier.<br><br>Not all of the attending crews were aware of the repeat nature of the calls; accurate communication of the deteriorating situation could possibly have resulted in earlier |

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| | successful resolution. During this time, Mr Smith's mental capacity was initially fluctuating and then deteriorated significantly during the 24th April.<br><br>On the afternoon of 24th April the final attending ambulance crew withdrew from attending Mr Smith at home in an attempt to de-escalate the situation. Mr Smith locked and partially barricaded the door and before police assistance arrived, set a fire within the entrance hall that quickly spread throughout the property. |
| 5 | **CORONER'S CONCERNS**<br><br>During the inquest it became apparent that the various East Midlands Ambulance staff attending Mr. Smith's address had no or very little training or awareness of alcohol withdrawal symptoms and potential complications. The court was properly directed to the JR CALC guidelines (Joint Royal Colleges Ambulance Liaison Committee), known as the ambulance crew's "bible" for training matters, which contains no guidance in relation to alcohol withdrawal. There is guidance regarding excessive alcohol consumption, but that was not an issue for my inquest.<br><br>The lack of awareness of symptoms experienced and displayed during withdrawal from alcohol may have contributed to the decisions made and outcome in this case, particularly in relation to fluctuating capacity and the patients ability to make decisions and understand information given to him. A better understanding of the presentation of this patient would possibly have resulted in him being brought safely into hospital for further assessment and treatment, and therefore removed the opportunity for him to set a fire whilst alone at home and die as a consequence.<br><br>East Midlands Ambulance Service wrote to your organization on 23 April 2019 highlighting this issue, but at the time this inquest concluded, no response had been received. I therefore take this opportunity to bring this matter to your attention again. |
| I. | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th July 2019. I, the Coroner, may extend the period.<br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>[redacted] (Mother) Represented by Bindmans<br><br>[redacted] (Partner)<br><br>[redacted] – Represented by Hempsons<br><br>East Midlands Ambulance Service – Rep Browne Jacobson<br><br>Leicestershire Fire and Rescue Services<br><br>Leicestershire Police Chief Constable - Represented by Police Legal |

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| | Leicestershire Partnership Trust – Represented by Weightmans<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **[DATE]** 23 May 2019 **[SIGNED BY CORONER]** |

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Chief Executive**<br>**East Midlands Ambulance Service** |
| 1 | **CORONER**<br><br>I am Lydia Charlotte Brown Assistant Coroner, for the area of Leicester City and Leicestershire South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 25th April 2018 I commenced an investigation into the death of Graham George Smith<br><br>The Inquest concluded on 21st May 2019<br><br>Cause of death:<br><br>Carbon monoxide poisoning as a result of a fire |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr. Smith died in a house fire at his home address, [redacted] Leicestershire on 24th April 2018.<br><br>**Narrative conclusion**<br>Mr. Smith had a history of drinking excess alcohol and taking unregulated and non-prescribed benzodiazepine medication he purchased over the internet. He required hospital treatment during 20th – 21st April 2018 when withdrawing from both alcohol and benzodiazepines and was then discharged home.<br><br>His condition started to deteriorate over the following days, and three separate calls were made for ambulance assistance, but on all occasions he refused to be transported back to hospital, against the advice of the attending crews and on the final occasion, also against the advice of his general practitioner. The crews had insufficient training or back-up resource material regarding alcohol withdrawal symptoms and were therefore unable to give full appropriate information to Mr. Smith, or assess his capacity fully. It is possible if this information had been available this would have led to Mr. Smith being taken to hospital earlier.<br><br>Not all of the attending crews were aware of the repeat nature of the calls; accurate communication of the deteriorating situation could possibly have resulted in earlier successful resolution. During this time, Mr. Smith's mental capacity was initially fluctuating and then deteriorated significantly during the 24th April. |

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| | On the afternoon of 24th April the final attending ambulance crew withdrew from attending Mr. Smith at home in an attempt to de-escalate the situation. Mr. Smith locked and partially barricaded the door and before police assistance arrived, set a fire within the entrance hall that quickly spread throughout the property. |
| 5 | **CORONER'S CONCERNS**<br><br>It became apparent during the course of the inquest that the emergency call handling system did not have the capacity to link repeat calls regarding the same patient at the same address within a short period of time. As the system is unable to currently link such patterns of call behavior, there is no system in place regarding how this information could be used for the benefit of patients and to introduce safety-netting. There was no senior review or "red flag" warning of heightened concern to alert the attending crews. The court was advised that if the history of recent calls had been known, this may have altered the way in which the attendance was managed.<br><br>It is acknowledged that any system to capture repeat calls will need to have careful consideration of multiple occupancy buildings and the need for confidentiality, but there may be good working models already achieving this aim, or parallels may be considered with sudden frequent attendances of patients to ED. |
| I. | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th July 2019. I, the Coroner, may extend the period.<br><br>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. |
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