Paul COOPER
HM Assistant Coroner
County of Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **East Midlands Ambulance Service** **CAT (Clinical Assessment Team)**
1.	**CORONER** I am Paul COOPER HM Assistant Coroner for the coroner area of Lincolnshire, 4 Lindum Road, Lincoln, Lincolnshire, LN2 1NN.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 21/11/2018 I commenced an investigation into the death of Helen BARKER, aged 50. The investigation concluded at the end of the inquest on 12/11/2019. The conclusion of the inquest was that Helen BARKER died as a result of Alcohol and Drug related, the medical cause of death being: 1a. Acute Ethanol Intoxication 1b. 1c. 2. Drug Toxicity
4.	**CIRCUMSTANCES OF THE DEATH** The deceased was a 50 year woman with a history of alcohol and depression. She called the emergency services on the 11th Nov 2018 to report she was feeling suicidal and threating to take an overdose. Reviews were supposedly undertaken at 22.39, 00.30 and 03.43 hours but these did not occur due to pressure at work. The paramedics eventually attended at 04.34 hours some 6 hours and 35 minutes after the initial call was made. The deceased was pronounced dead at her home on 12th November 2018 at 4 Bexon Court, Louth
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. A serious level investigation report (reference SI 2018/27277) made 5 recommendations, the fifth appearing on page 15 which reads as follows:- Consider the feasibility of the CAT Team Leader making contact with NHS 111 when it is noted that there is an increase in the number of C3 coded calls that have not been assessed by a NHS 111 Clinician before being passed to the Trust. Has this recommendation now been implemented particularly where attempted suicides have been reported. Why can't EMAS escalate a category 3 status to a category 2 status when their own call out time of 120 minutes for an ambulance on a category 3 status has been exceeded?
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 14/01/2020. 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 (a) Next of kin (b) East Midlands Ambulance Service 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.
	Date: 19/11/2019

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	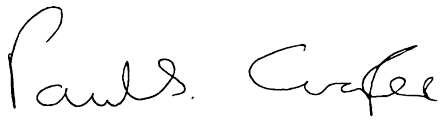 Paul COOPER HM Assistant Coroner