REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England** **2. London Ambulance Service** **3. College of Policing**
1	**CORONER** I am Jonathan Landau, assistant coroner for the coroner area of South London
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 19 August 2020 an investigation was commenced into the death of Richard Boateng aged 23. The investigation concluded at the end of the inquest on 24 September 2021. The conclusion of theinquest was as follows: Mr Richard Boateng phoned his GP surgery on 30 March 2020. He was very unwell. A GP called him the next morning and although he answered the phone he was not able to complete sentences or give his full name. He was on a bench in the street from at least 10.30am that day. Police were called and attended at 4pm. An ambulance arrived at 6.23. Despite attempts at resuscitation, Richard died from Covid 19 shortly after his arrival at Croydon University Hospital on the evening of 31 March 2021.
4	**CIRCUMSTANCES OF THE DEATH** See 3 above.
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) **NHS England.** A call to the GP surgery the day before Richard's death was taken by a receptionist who arranged a routine appointment. She was not a clinician and only had on the job training. The surgery has since introduced a system called Klinic which is safer. It prompts questions and uses an algorithm to alert any urgent or emergency calls that are then flagged. All calls are also reviewed by clinicians. However, I am concerned that other surgeries may employ non-clinicians who may be required to make judgments as to the urgency of appointments, and there is no guidance available to surgeries as to how to mitigate the risks of this.

	(2) **London Ambulance Service.** The GP called LAS concerned about Richard's welfare. LAS attended his home address. Richard was not there. The LAS paramedic advised his sister to call the police. The LAS quality manager accepted in evidence that it would have been better to have taken her number and to pass it on to the police to make contact. I was told that national guidance on this issue was published in the summer. To date, neither guidance to crews nor to control had been updated to make the LAS guidance clearer to those applying it. (3) **College of Policing.** Due to the Covid pandemic, no ambulances were available when police attended to Richard. The Metropolitan Police Service had a policy that permitted conveying patients to hospital in an emergency if no ambulances were available. However, the policy included no practical guidance as to how that could be achieved mitigating the risks. I heard that the Metropolitan Police Service is updating the guidance. However, I am concerned that other forces across the country may also lack such practical guidance, which is of particular concern due to ongoing pandemic and the demands that may continue of ambulance services.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 23 November 2021. 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 am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find ituseful or of interest. 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.
9	 **Jonathan Landau, HM Assistant Coroner** **28 September 2021**