C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **NHS Pathways**
1	**CORONER** I am CRISPIN GILES BUTLER, Senior Coroner for the coroner area of Buckinghamshire
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/pdfs/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 23rd November 2018 I commenced an investigation into the death of Alf REWIN. The investigation concluded at the end of the inquest on 25th September 2019. The medical cause of death was: 1a Drug Intoxication The narrative conclusion was: "Although Alf Rewin undertook the act which led to his death there are no indications that at the time he did this he intended his death as a result and his other actions on the evening of 21st November 2018, in particular seeking assistance of emergency services, support the position that, on balance, having consumed the medication, it is more likely that Alf did not intend to die. It is not possible to conclude that if an ambulance had been dispatched earlier Alf would have survived."
4	**CIRCUMSTANCES OF THE DEATH** Alf Rewin's death was confirmed at 00:00hrs on 22nd November 2018 at Wexham Park Hospital, Berkshire. He had died from the combined toxic effects of Quetiapine, Methylphenidate and Duloxetine. He had called from his home address in Buckinghamshire and spoken to the ambulance services at 20:47hrs on 21st November 2018 confirming he had taken an overdose. Alf was unresponsive when attended by paramedics at 22:47hrs and arrived at Wexham Park Hospital at 23:42hrs but could not be resuscitated.
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.

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	The **MATTERS OF CONCERN** are as follows. The National Ambulance Call Categories prescribed by NHS Pathways to ambulance services, including South Central Ambulance Service, who were the attending service in relation to Alf Rewin's death, indicate that an individual contacting emergency services himself or herself, having taken an overdose may be triaged through the national call handling pathway to a Category 3 Urgent Call. This category currently prescribes a target attendance within 120 minutes. There is a concern that in cases of overdose, the patient is at risk of becoming unconscious or having a cardiac arrest or other potentially fatal event and will be unable to contact emergency services or be contacted by them subsequently, such that his or her call should at that stage then be regarded as Category 1 (with a 7 minute response time) or Category 2 (with an 18 minute response time). In Alf Rewin's case, there existed a local policy to override the Category 3 120-minute response in overdose cases to provide a specific triage which could lead to a Category 2 18-minute response (although the 18-minute response was not, in fact, implemented at the outset in Alf Rewin's case and he was initially allocated the national Category 3 response). It is understood that the national categorisation of overdose cases is under review. Whilst the Category 3 120-minute target may be the standard, subject to local variation, in relation to overdose cases where the patient is conscious, the risk of deaths arising during this period remains where the circumstances of the overdose might enable some counteractive treatment to be given, or successful resuscitation measures to be carried out, if there were to be earlier attendance and / or earlier hospitalisation.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd December 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: The family of Alf Rewin South Central Ambulance Service I am also under a duty to send the Chief Coroner a copy of your response.

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	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	**7th October 2019** **Crispin Butler, Senior Coroner for Buckinghamshire**

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