David Ridley
HM Senior Coroner
for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: [redacted] Chief Executive South Western Ambulance Trust Trust Headquarters Abbey Court Eagle Way Exeter Devon EX2 7HY [redacted] Executive Officer The Association of Ambulance Chief Executives MBF GG322 30 Great Guildford Street London SE1 0HS [redacted] CQC National Customer Service Centre Citygate Gallowgate Newcastle upon Tyne NE1 4PA CQCInquestsandCoroners1@cqc.org.uk
1	**CORONER** I am David Ridley, Senior Coroner for Wiltshire and Swindon
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 the 16 December 2019 I commenced an investigation into the death of Mary Grace JOHNSON (aged 98) which occurred during the early hours on 10 December 2019. I opened an Inquest into her death on the 4 March 2020. On 27 March 2020 I commenced an investigation into the death of Vhari INGALL (aged 54) and

	have authorised a post mortem examination with a view to confirming the cause of her death. Mrs Ingall's death was confirmed by an attending paramedic at 0105 earlier that day on 27 March 2020. The cause of death in relation to Mary JOHNSON which is subject to final determination at Inquest, but which I have to say is unlikely to change, is **tramadol toxicity**. In both of these cases, they have involved paramedic attendance and an awareness and belief that both of these individuals had separately taken an overdose by way of self-harm. In relation to Mrs. Johnson it is believed that she was found at her home at [redacted] Christian Malford, Chippenham, Wiltshire on the 9th December 2019 by her daughter with a glass with white powder residue in it and a note explaining that Mrs. Johnson "*had a good life and wanted to die at home*", 2 further notes were located in the bedside table. Paramedics were called to the property and they produced an advanced directive and I also understand that there was a Do Not Resuscitate form. Some of Mrs. Johnson's family, who were present at the time were insistent that she should not be taken to hospital and the paramedics sought advice from their control room as to what to do and the decision was taken to leave the lady to die at home. The SWAST report refers to "...*it was a potential best interest decision to leave the patient on scene and allow for natural death.*" I understand in relation to Ms. Ingall, following the arrival of Paramedics at her home at [redacted] Royal Wootton Bassett, Wiltshire that despite their encouragement for her to go to hospital she refused. It was believed that Ms Ingall had taken an overdose of medication. It would appear that there were mental capacity concerns. The Paramedics sought Police involvement but shortly after police arrival it is understood that she became unresponsive. The Paramedics were aware again of a Do Not Resuscitate form and when she became unresponsive did not carry out any form of resuscitation measures on the basis of its existence. It is believed that Ms Ingall has died as a result of excess medication and this is currently being investigated.
4	**CIRCUMSTANCES OF THE DEATH** See above
5	**CORONER'S CONCERNS** Even though neither of these cases have proceeded to a final Inquest hearing in accordance with Regulation 28 of the Coroners (Investigation) Regulation 2013 a report to prevent future deaths can be made if evidence comes before the Coroner that causes a concern and triggers the Coroner's duty to submit such a report if the Coroner thinks it is appropriate. I am of the view that this duty has now been triggered because the death of Ms. Ingall raises the same issue and concern that I have following the death of Mrs. Johnson. The concern is that the **Do Not Resuscitate** document applies to allow specifically a natural death. We know that Mrs. Johnson did not die a natural cause of death and there were sufficient information indicators at the scene and the Paramedics were aware that she had taken, more likely than not, an overdose. The same appears to be the case with Ms. Ingall although this is subject to confirmation following the post mortem examination. A person dying as a result of self-harm and as a result of an overdose cannot if any way whatsoever be regarded as a natural death, it is my view and concern that Paramedics are being placed in a difficult position as well of those that they are responsible for caring for if they do not intervene appropriately. It may be the case at hospital and potentially with the involvement of mental health professionals that a decision is taken to withdraw treatment, but I am concerned, especially having regard to Article 2 of the European Convention of Human Rights that that decision is not taken by frontline Paramedics and I would ask you to urgently review the instructions and guidance given to your frontline Paramedics in these situations.

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. This is a revised report to Prevent Future Deaths which is being sent to additional recipients as I now have a genuine belief that this may potentially be a wider issue nationally and not just limited to the NHS Ambulance Trust covering the South West.
7.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, unless I have extended this 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. I have already granted SWAST an extension until 26 July 2020, at their request, but I am now aware from recent correspondence that their investigations will not be concluded until early August 2020. Responses are therefore to be received by 1 September 2020 unless a further extension is requested and granted by me.
8.	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Person, Daughter of Mrs. Johnson Sister of Ms. Ingall 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.	Dated 7 May 2020 Signature _____ David Ridley, Senior Coroner for Wiltshire & Swindon

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