ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **at Welsh Ambulance NHS Trust**
1	**CORONER** I am Graeme Hughes, H M Senior Coroner, for the coroner area of South Wales Central.
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 3.11.20, I commenced an investigation into the death of Sarah Marie GILBERT-JONES. The investigation concluded at the end of an inquest on 3rd February 2022. The conclusion of the inquest was:- The deceased died due to the direct effects of a significant and deliberate overdose of her prescription medication. It is unlikely that she intended the consequences of that overdose to be her own death. It is likely that the timing of her death was contributed to by her sub-optimal transfer to hospital, narrowing the opportunity for administering effective life-saving medication and treatment. The cause of death being: 1a: [redacted] Toxicity
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Since 2019, Sarah Marie GILBERT-JONES, had experienced fluctuating and worsening mental health. This had manifested itself in episodes of self-harm, and from the summer of 2020 overdoses of her prescription medication. On the evening of 28.10.20 she has taken a significant overdose, concurrently with a large quantity of alcohol. A delay in the arrival of the emergency services compromised an opportunity for earlier life-saving treatment. She died in the early hours of 2910.20 at the Royal Glamorgan Hospital. The cause of her death due directly to the toxic effects of the overdose. The Inquest broadly focused upon:- a. The emergency response following notification of the overdose & request for ambulance assistance. In particular, the *grading* of calls to the Clinical Contact Centre & the actions initiated following the same b. Whether a delay(s) in ambulance service attendance (upon the deceased) &

	conveyance to an Accident & Emergency Department, contributed to her death c. The contribution, if any, of sub-optimal Mental Health Services provision upon her death
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) When the initial 999 call was placed by the deceased's father at 22.05 on 28.10.20, it was accepted that he explicitly indicated to the Call Handler that the deceased had taken an overdose of, inter alia, [redacted] tablets. Based upon that, & answers to other questions posed by the call handler, the call handler selected a protocol which did not appear to require this crucial piece of information to be either recorded within it, or to form part of the material which led to the categorisation of the call for the purposes of determing the appropriate response. In short, it led to a categorisation which could only loosely provide a response (based upon the level of demand that evening) estimate of around 3 hours. The concern here is that treatment for a massive [redacted] overdose is *time critical,* & the processing of the call did not appear to accurately reflect the peril the deceased was then in, nor the importance of providing an acute emergency response. (2) There appeared to be an opportunity shortly following the initial categorisation of the response, by a clinical floor walker, to upgrade to a code/categorisation which would likely have led to a swifter response, but an under-appreciation, or otherwise, of the then time critical treatment window open to the deceased. I was informed in evidence that the clinical floor walker would have had access to TOXBASE via the Clinical Support Desk at that time, & had that been accessed & information promptly secured regarding the treatment indicated, this would have alerted the clinician to the need for an acute emergency response. This was subsequently undertaken by the attending paramedic (albeit not via TOXBASE) some hours later, & who immediately after having accessed the treatments for massive [redacted] overdose, appreciated that the deceased was a time sensitive patient & to convey to the emergency department with all haste. (3) Following the second call to Clinical Contact Centre at 23.48 on 28.10.20, there were somewhat bewilderingly complex, & inconsistent categorisations of the code for response which appeared to lead to response vehicles being despatched or stood down, whilst the patient remained in need of time sensitive treatment by way of transfer to an Accident & Emergency Unit. Whilst I was assured that this had been addressed by learning & guidance to call handlers, a review of categorisations, coding's & actions in the setting of a patient demonstrating the symptoms as per the deceased on 28/29 October 2020 to achieve clarity/consistency is invited.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 1st April 2022. Only, 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 deceased's family and the Health Inspectorate Wales, Cwm Taf Health Board who may find it useful or of interest. 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	4th February 2022 **SIGNED:**  Graeme Hughes, H M Senior Coroner for **South Wales Central**