	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1)** NHS England, Legal Team, 4W08 4th Floor, Quarry House, Leeds LS2 7UE. **(2)** NHS Digital, 1 Trevelyan Square, Boar Lane, Leeds, LS1 6AE.
1	**CORONER** I am James Bennett, Area Coroner for **Birmingham and Solihull**
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 11 April 2019 I commenced an investigation into the death of Allan Davies. The investigation concluded at the end of an inquest on 26th June 2019. The conclusion of the inquest was his death was drug related.
4	**CIRCUMSTANCES OF THE DEATH** Mr Davies had a long history of misusing illicit drugs and was diagnosed with personality and substance misuse disorders. He had overdosed many times and had recently been warned by his GP about the on-going risk. On 7/02/19 he telephoned 999 and reported that he had inadvertently taken too much heroin, crack cocaine and mamba two hours earlier, and he had some breathlessness. In accordance with national NHS guidelines the ambulance service assessed the case as a category 3, with a target of an ambulance attending within two hours. Over the next two hours five ambulances were dispatched, but on route they were transferred to higher category patients in a period of high demand. A welfare call was made to Mr Davies at 19.11hrs, which went unanswered, prompting an ambulance to be dispatched at 19.17hrs, arriving at 19.28hrs. Mr Davies was found lying on the floor in his flat in cardiac arrest. CPR was unsuccessful and he was certified deceased at 20.19hrs. Following a post mortem the medical cause of death was determined to be: heroin overdose.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. I heard evidence from a West Midlands Ambulance Service (WMAS) Clinical Standards Manager and Emergency Operations Centre Clinical Manager. They explained that it is recognised certain drugs put overdose patients who are initially breathing and conscious at greater risk of sudden collapse. An example given of the two ends of spectrum was a paracetamol overdose – less risk of sudden collapse – and heroin overdose – greater risk of sudden collapse. However, when an overdose patient calls 999, the NHS Pathways Telephone Triage System (NHSP) does not distinguish between the type of drug(s) taken and the corresponding risk of sudden collapse. If the patient is breathing and conscious at the time of the call, NHSP advises a category 3 response (ambulance within two hours), regardless of the type of drug(s) taken. Both witnesses expressed concern that this is too generic and is placing patients at risk. One of the witnesses sits on the NHSP user group, and added the generic triaging of overdose cases continues despite a number of different NHS trusts sharing the same concern and raising it with NHS Pathways via the user group. WMAS are sufficiently concerned about the on-going concern that in January 2019 they implemented a local policy adding a layer of triaging on top of NHSP to have regard to the type of drug(s) taken and its impact on the patient. My on-going concern is: (1) NHSP triaging of overdose cases is too generic, namely it fails to have regard to the type of drug(s) taken and the potential for sudden collapse in certain patients; (2) Not all NHS trusts/ambulance services that utilise NHSP are aware of this apparent deficiency. 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.

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 5 September 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: (1) West Midlands Ambulance Service, (2) Birmingham and Solihull Mental Health NHS Trust, and (3) Allan Davies' next of kin. I have also sent it to the following who may find it useful or of interest: (1) NHS Clinical Commissioning Group Birmingham and Solihull Group, (2) Department of Health and Social Care. 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	09/07/2019 Signature  James Bennett **Area Coroner Birmingham and Solihull**