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:** **1. Chief Executive – West Midlands Ambulance Service**
1	**CORONER** I am S McGovern, senior coroner, for the coroner area of Warwickshire.
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 2019 I commenced an investigation into the death of, Ashley WALKER, 25 years old. The investigation concluded at the end of the inquest on 30 January 2020. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 17 August 2019, Mr Walker telephoned West Midland Ambulance Service (WMAS) and informed them he had ingested [redacted]. An ambulance crew was dispatched to his property and arrived at 1324. On arrival Mr Walker's Glasgow Coma Score was 3 which increased to 6 after the administration of oxygen. The crew continued to treat Mr Walker until 1345 when they were directed to leave as the scene was said to be hazardous to their health. The scene was not hazardous and there was no requirement for the crew to leave. Mr Walker was left unattended for 45 minutes until the fire crew extricated him from the building. He was not breathing when he was extricated. I heard evidence that he had ' a real chance of survival' had the crew not left.
5	**<u>CORONER'S CONCERNS</u>** 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) It is apparent that a communication error confused the <u>ingestion</u> of [redacted] with a <u>spillage</u> of [redacted]. (2) [redacted] toxicity is a recognised method of suicide and I heard evidence from a WMAS staff member that there is an effective antidote (methylene blue) but this was not available on the ambulance.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive of the WMAS 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 27 March 2020. 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 – (a) Family of Mr Walker (via his mother [redacted]) 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	**31 January 2020** **Senior Coroner S McGovern**