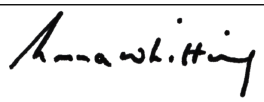
Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: Emergency Call Prioritisation Advisory Group (ECPAG), Association of Ambulance Chief Executives, National Association of Ambulance Medical Directors
1	**CORONER** I am Emma WHITTING, Senior Coroner for the area of Bedfordshire and Luton Coroner Service
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 Twenty-Eighth July 2019 I commenced an Investigation into the death of Helen Jayne SHEATH aged 33. The investigation concluded at the end of the inquest on Tenth December 2019. The conclusion of the inquest was a Narrative Conclusion :*The Deceased died from a fatal dose of sodium nitrate; although this was procured by the Deceased and self-administered, her intentions in doing so were unclear.* The medical cause of death was: Ia Fatal Methemoglobinemia Ib Ingestion of Sodium Nitrate II Excess use of Fluoxetine
4	**CIRCUMSTANCES OF THE DEATH** The Deceased had a recent history of self-harm and suicidal ideation which had resulted in several in-patient psychiatric admissions. Following her discharge from the last admission in Townsend Court on 3 July 2019 she was still awaiting an Out-Patient Appointment with psychological assessment and treatment from the Community Mental Health Team when, whilst at home, she ingested a fatal dose of sodium nitrate at around 6.30pm on 20 August 2018. Paramedics were first called at 6.20pm and attended to her at 7.05pm; however, soon after their arrival, she became acutely unwell. She was admitted to Bedford Hospital but, despite treatment, her death was confirmed there at 8.25pm. Although the Community Mental Health Team had been alerted to her threats to harm herself and had attended her home earlier that

	afternoon they had left before being able to gain access even though a family member was due to attend later with a key. Although their continued presence at the property would not necessarily have avoided the fatal outcome it could potentially have done so.
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) Helen's father first called ambulance services at 18.20 hours on 2018 which was before she had ingested the sodium nitrate. EEAS's investigation report stated that "*from the information provided on this call, that Helen had locked herself in the bathroom and was threatening to self-harm by ingesting a substance, the call handler selected the set of questions titled "Psychiatric/Abnormal Behaviour/Suicide Attempt" and the call was coded as a Category 3. This call has been audited by the Quality Assurance Team and was correctly coded and the correct set of questions used*" ….yet a Category 3 call is for patients who have potentially urgent conditions that are <u>not</u> life threatening and yet Helen had a history of suicide ideation and her father <u>was unable to tell, being the other side of the locked door, whether the substance had been taken or not</u>. In view of both Helen's past medical history and the fact that her father had no knowledge as to whether the substance had been ingested or not at that stage, it seemed to the Court that an assumption that an overdose had been taken ought to have been made and this first call, therefore, coded as a Category 2; (2) Although a Double Staffed Ambulance (DSA) was dispatched at 18.30 hours, it was diverted on route to a higher priority emergency call and it was only after a second call was made to ambulance services at 18.48 hours, when the call handler selected the set of questions titled "*Overdose/Poisoning/Ingestion*" because it was said that it was suggested on this call that she had ingested the substance that the call was coded a Category 2 and that, due to the lack of DSA availability, at 18.57 hours a Rapid Response Vehicle (RRV) was dispatched with the Mental Health Street Triage Team who arrived at 19.05 and 19.11 hours respectively with a different DSA arriving at 19.25 hours. (3) If the first call had been coded as a Category 2, it seems likely that the RRV, Mental Health Street Triage Team (and even possibly the original DSA) would have arrived on scene much earlier (potentially just before or just after Helen had ingested the sodium nitrate) which could potentially have altered the outcome.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you «Contactfullname» 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 24 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: East of England Ambulance Service NHS Trust, [redacted] (Deceased's brother) and East London NHS Foundation Trust. 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	 Emma WHITTING Senior Coroner for Bedfordshire and Luton Coroner Service Dated: 27 January 2020