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:** **Emergency Call Prioritisation Advisory Group (ECPAG)** **Association of Ambulance Chief Executives** **AACE's National Directors of Operations Group** **National Association of Ambulance Medical Directors**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 22 may 2019 I commenced an investigation into the death of Sarah Ferneyhough a 30 year old young woman who died on 22 May 2019 at [redacted] Abels Road Halstead. The investigation concluded at the end of the inquest on 10 February 2020. The conclusion of the inquest was expressed as a Narrative viz:- The deceased died at her home address in the early hours of 22 May 2019. She had taken an overdose of venlafaxine, amisulpride and hydroxyzine as well as cocaine, cannabis and alcohol. At 23.53am on 21 May 2019 she called the ambulance service but on attendance of fire and ambulance crews at 3.04am on 22 May she could not be resuscitated. There was a delay in the attendance and failings in the procedures in place for the categorisation of calls. It is not certain whether, if paramedics had arrived sooner, she would have survived. The evidence does not indicate on the balance of probabilities that the deceased intended to take her own life.
4	**CIRCUMSTANCES OF THE DEATH** See above The medical cause of death was 1a) alcohol and multiple drug toxicity
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. The deceased's call was described as an "abandoned call" and thereafter automatically categorised as a category 3 A review of this practice is required.

	2. A review is required as to whether it is appropriate for all reported medical conditions to be categorised no higher than category 3 3. In the situation leading up to Ms Ferneyhough's death, the duty EOC who had authority to upgrade the categorisation of the call did not listen to the recording of the "abandoned" call and was not provided with full details of any medical information given. Measures could be put in place to ensure that the duty EOC or other person who has authority to upgrade the categorisation of calls is asked to listen to the recording of the "abandoned" call or provided with full details of any medical information given. 1.
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 16th December 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 Trust – Hempsons solicitors Solicitors for the family 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	**Mrs Caroline Beasley-Murray senior coroner Essex**