IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Ginger Wright
Otherwise Known as Mark Steven Wright
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Officer South East Coast Ambulance Service (SECAMBS) 4 Gatwick Road Crawley Sussex RH10 9BG Rt. Hon. Steve Barclay Secretary of State for Health and Social Care 39 Victoria Street London SW1H OEU
2	**CORONER** Miss Anna Crawford, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

4	**INQUEST** An inquest into the death of Mr Wright was opened on 5 July 2022. The inquest resumed on 22 May 2023 and concluded on 6 June 2023. The medical cause of Mr Wright's death was: 1a. Quetiapine Toxicity The inquest concluded with a narrative conclusion as follows: 'On the night of 14 June 2022 or the early hours of the morning on 15 June 2022 Mr Wright took a deliberate overdose of his prescribed quetiapine medication at his home address. At the time he took the overdose he intended to take his own life. After he had taken the overdose he spoke to a friend on the phone and allowed her to call an ambulance for him. He also propped the front door open so that the ambulance would be able to gain access on their arrival. However, on the arrival of the ambulance crew Mr Wright was found to be deceased. His death was due to quetiapine toxicity.'
5	**CIRCUMSTANCES OF THE DEATH** In the early hours of the morning on 15 June 2022 Mr Wright's friend [redacted] sent him a text message and Mr Wright called [redacted] and told [redacted] that he had taken [redacted] quetiapine tablets and he wanted to die. [redacted] managed to persuade him to let [redacted] call an ambulance. At 04:58 [redacted] rang 999 and informed the operator that Mr Wright was conscious and breathing but that he had taken an overdose. [redacted] provided the details of what he had taken. [redacted] then called Mr Wright back and remained on the phone to him whilst they waited for the ambulance. At 05:26 [redacted] rang 999 again and reported that she thought that Mr Wright was now unconscious and she did not know if he was breathing or not. At 06:40 an ambulance arrived at Mr Wright's address and he was pronounced deceased at 07:39. The court found that there was a delay from 05:10 onwards in carrying out an urgent clinical review of the first 999 call by staff at the Emergency Control Room at South East Coast Ambulance Service (SECAMB). Had a clinical review taken place at 05:10, the call would have been upgraded to

a Category 2 call with a target response time of 18 minutes from the original call. In fact, the call was not upgraded to a Category 2 call until [redacted] called back at 05:26, and thereafter an ambulance did not arrive at Mr Wright's address until 06:40, one hour and 14 minutes later.

Whilst the above delays are clearly a matter of concern, the court was not persuaded that they materially contributed to Mr Wright's death.

The initial delay at 05:10 was due to individual error and therefore does not form part of the concerns which you are asked to address in response to this report.

However, the subsequent delay, which occurred following the second 999 call at 05:26, was because SECAMBS was in Stage 4 of its Surge Management Plan, meaning that demand for the service was significantly outstripping available resources and the service was not capable of responding to calls within target timeframes.

During the inquest the court heard evidence from [redacted] Clinical Manager at SECAMBS Emergency Control Room. [redacted] gave evidence that during the last reported quarter, namely January to April 2023, SECAMBS had been operating at Stage 4 of its Surge Management Plan for 11.71 per cent of the time. In the previous quarter of September to December 2022, the Trust had been operating at Stage 4 for 45.73 per cent of the time.

[redacted] informed the court that there were various reasons for SECAMBS being in Stage 4 of the Surge Management Plan on such a frequent basis, including lengthy waiting times to hand patients over to hospitals, insufficient staff numbers despite efforts to recruit both here and abroad, as well as high numbers of staff sickness.

Whilst the reported figures indicate a notable reduction in the amount of time SECAMBS is spending in Stage 4 of the Surge Management Plan as compared with the latter half of 2022, it remains a matter of significant concern that the Trust is unable to respond to calls within target timeframes for 11.71 per cent of the time.

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: There is a risk of a future reoccurrence of the situation which arose on 14 June 2022 given that SECAMBS is regularly operating at Stage 4 of its Surge Management Plan, meaning that demand for the service is significantly outstripping available resources and the service is not capable of responding to calls within target timeframes.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Wright's family
10	**Signed:** **ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 26th day of June 2023**