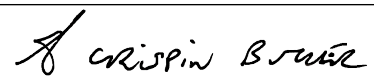
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** 1. **NATIONAL AMBULANCE RESILIENCE UNIT (NARU)** 2. **NATIONAL AMBULANCE SERVICE MEDICAL DIRECTORS (NASMeD)** 3. **ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES (AACE)** 4. **NHS ENGLAND (NHS Pathways)** 5. **NATIONAL CODING GROUP (Central Ambulance Team)** 6. **EMERGENCY CALL PRIORITISATION ADVISORY GROUP (ECPAG)**
1	**CORONER** I am Crispin Giles BUTLER, Senior Coroner for the coroner area of Buckinghamshire
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 15th July 2020 I commenced an investigation into the death of Fern Elisabeth Foster, aged 22. The investigation concluded at the end of the inquest on 18th April 2024. The medical cause of Fern's death was [redacted] A narrative conclusion was recorded: "Suicide to which the following contributed more than minimally: (a) Fern Foster did not have access to independent advocacy from an early stage in 2019, and thereafter on a regular, consistent and continuous basis, nor on the 8th July 2020 when she learned of significant news likely to trigger suicidal intention; (b) the manner in which Fern learned of the significant adverse news, in the absence of physical professional support, probably caused Fern to act as she did, at the time she did, with the intention of ending her life."
4	**CIRCUMSTANCES OF THE DEATH** Fern Foster's death was verified at around 15:20 on 8th July 2020 at her current accommodation. Fern had received news that day concerning the intended adoption of her child in circumstances where professional support, including independent advocacy, was not physically present at the time to try to assist Fern with processing the information, to safeguard her mental wellbeing and to address her likely increased risk of suicide. Fern had previously indicated her intention to end her life, were her child to be adopted, and had also taken two overdoses in March with the likely intention of ending her life, although she received treatment and survived on both occasions. Fern had procured a different substance at the end of March and when, on 8th July 2020, she consumed some of the contents from the package in her possession, she intended her death to result. Fern had a pre-existing, well-established, accepted, and recognised diagnosis of Autism Spectrum Disorder
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 could 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 process for triaging and prioritising ambulance attendance to an incident involving the suspected ingestion of [redacted] (intentionally or otherwise) does not provide sufficient opportunity for travel, attendance, conveyance to hospital for emergency treatment and/or provision of antidote treatment at scene, which may provide the only likely means of prevention of death where sufficient quantity has been ingested. (2) The carrying by ambulance services of appropriate antidote medication for on-scene administration (such as Methylene Blue), whilst trialled elsewhere, is not part of regional or national protocol. Swift access to this in circumstances where [redacted] is suspected, and timings mitigate against survival by the time of arrival at the nearest Emergency Department, could prevent future deaths in some cases.
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 **2nd August 2024**. 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: The Family of Fern Foster [redacted] South Central Ambulance Service Thames Valley Air Ambulance Buckinghamshire Council Adult Services Buckinghamshire Council Children's Services Oxford Health NHS Foundation Trust I have also provided a copy to: Thames Valley Police Buckinghamshire Safeguarding Adults Board 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	**Dated: 07/06/2024**

	 **Crispin Giles BUTLER** **Senior Coroner for** **Buckinghamshire**