	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted]**,** CHIEF EXECUTIVE, WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST
1	**CORONER** I am EDWARD RAMSAY, His Majesty's Assistant Coroner for the coroner area of SWANSEA AND NEATH PORT TALBOT.
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 7 JULY 2020 the Senior Coroner commenced an investigation into the death of STEFAN WALKER aged 40 (hereafter "STEFAN"), who died on 29 June 2020. The investigation concluded at the end of the inquest held between 20th and 28th May 2024. The said investigation was one to which the enhanced investigative obligation, under Article 2 of the European Convention on Human Rights, applied. The conclusion of the inquest jury was that STEFAN'S death was '*Drug related*' – the medical cause of death being '*buprenorphine and flualprazolam intoxication, and cardiac enlargement*' and that, inter alia, '*Stefan died in his bedspace at Cefn Coed Hospital, Swansea on 29 June 2020 sometime between 1520 and 1545'*.
4	**CIRCUMSTANCES OF THE DEATH** (1) At the time of his death STEFAN was a detained patient under the Mental Health Act 1983 and receiving in-patient psychiatric treatment on Fendrod Ward on account of his diagnosis of polysubstance misuse, psychosis, Emotionally Unstable Personality Disorder, and ADHD. (2) The evidence that I and the jury heard was to the effect that on both 28th and 29th June 2020 there were concerns that STEFAN had consumed illicit substances and was displaying symptoms of being physically unwell (overly sedated and drowsy, slurring his speech and tripping over his feet, unable to keep his eyes open and perspiring profusely). He disclosed to staff that he had taken 'street diazepam'. (3) In the afternoon of 29 June 2020 he was found unresponsive in his room and attempts were made by nursing staff and paramedics to resuscitate him. The evidence and the jury heard was that STEFAN was displaying no signs of life when he was found. (4) Naloxone and Flumazenil were both administered by a junior doctor and the ward pharmacist with the assistance of the paramedics when they arrived – the Flumazenil only because it was kept on the ward. It was not carried by the paramedics, and I was told that it is not carried by paramedics. (5) Toxicology after his death revealed the presence of both buprenorphine (strong opioid analgesic) and flualprazolam (novel designer benzodiazepine). (6) Flumazenil is a potential antagonist in relation to the novel designer benzodiazepine.

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 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) I was told that **paramedics and ambulance crew do not carry flumazenil** (but often do carry naloxone). The availability of flumazenil was happenstance in this case because STEFAN was on an acute psychiatric ward where the said antagonist was being kept and could be prescribed by the ward pharmacist and administered by the doctors (with the support paramedics when they arrived). (2) I am concerned that there may be other acute circumstances when the use of this particular antagonist (flumazenil) could make a difference (say in the case of the collapse of person on the street or otherwise in the community) but will not be available since paramedics do not it. (3) I and the jury heard no evidence as to why naloxone is carried, but other antagonists (such as flumazenil) not.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 **12 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 (1) STEFAN'S Family (2) Swansea Bay University Health Board (3) City and Council of Swansea I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.

9	**17 June 2024** **EDWARD RAMSAY** HM ASSISTANT CORONER FOR SWANSEA AND NEATH PORT TALBOT