REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive of North East Ambulance Service**
1	**CORONER** I am Janine Richards, assistant coroner, for the coroner area of Durham and Darlington.
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** On the 11th of July 2023 an investigation was commenced into the death of Sophie Jayne Wilson, aged 26 years. The investigation concluded at the end of an Inquest on the 1st of August 2024. I gave a narrative conclusion which included that the cumulative failings of mental health services and the North East Ambulance Service contributed more than minimally to the death.
4	**CIRCUMSTANCES OF THE DEATH** Sophie Jayne Wilson was found deceased at her home address on the 2nd of July 2023. She died as a result of an [redacted] Overdose. Having disclosed an [redacted] overdose to the Crisis team the evening before an ambulance was called on her behalf. Sophie did not engage with the ambulance crew or the paramedic to whom the case was escalated and refused their assistance. They left the scene. There was no assessment of her capacity to decline potentially life-saving assessment and treatment. There was no escalation to the Police to force entry. There was no formal escalation to mental health services. There was no reference to the 'familiar face multi agency plan' which neither the ambulance crew or paramedic had seen. Some 21 hours after Sophie had told the crisis team of her overdose and the ambulance had been called, the Police forced entry to her home and found her deceased.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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) Although I received reassurance following the internal investigation that actions have been completed and lessons learnt in relation to this death, I remain concerned about the fact that the ambulance crew and paramedic were entirely unaware of the familiar faces plan in place for Sophie which contained crucially important information pertinent as to how best to assist her, secure her engagement and in relation to issues of both capacity and risk. I was told in evidence that the difficulty related to a data limit upon the electronic devices utilised by NEAS, and that therefore there should be a flag on electronic communications and that the control room would need to be contacted to obtain the additional information. NEAS were a signatory to the multi agency familiar face plan in this case which applies to them as well as a number of other agencies and was designed to assist in supporting the deceased and to reduce the risk of harm. (2) I am concerned that the information was not seen by the ambulance crew and paramedic who attended, and I am not reassured that it will be available to first responders on future occasions as it seems that the limits of the technology require the ambulance crew or paramedic to spot the flag and to contact the control room, presumably for a verbal account of the information only. I am concerned that in an emergency situation and when services are under such pressure that crucial information, such as a multi agency familiar face plan is not easily accessible to those attempting to offer assistance to some of the most vulnerable people in society.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 27th of September 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 the deceased, Tees Esk and Wear Valley Foundation Trust (TEWV), and the County Durham and Darlington Trust (CDDFT). 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	**02.08.24 HMAC Richards**