Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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<tr><td></td><td>REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 The Emergency Call Prioritisation Group (ECPAG)
2 Association Of Ambulance Chief Executives (AACE)
3 National Ambulance Service Medical Directors (NASMeD)</td></tr>
<tr><td>1</td><td>CORONER

I am Christopher LEACH, Assistant Coroner for Norfolk</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 29 August 2023 I commenced an investigation into the death of Aran Sean BRADBURY aged 34. The investigation concluded at the end of the inquest on 16 October 2024.

The medical cause of death was:
1a) Hypoxic Ischaemic Brain Injury
1b) Cardiac Arrest
1c) Hanging
2)

The conclusion of the inquest was:
On 21 August 2023, Mr Aran Sean Bradbury applied a ligature to his own neck. His intention when he did so is unknown. As a result of applying the ligature, Mr Bradbury went into cardiac arrest. There was a delay of two hours between a call being made to 999 and an ambulance being despatched. Advance Life Support was provided by ambulance crews on arrival at the scene and Mr Bradbury was resuscitated and transferred to the Norfolk and Norwich University Hospital where scans identified the brain injury which caused Mr Bradbury's death on 25 August 2023.</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH

On 21st August 2023 at 13:07 a member of the local Drugs and Alcohol Service called 999 because of concerns about Mr Bradbury following a phone conversation with him and a separate call to the Service from his mother. The call expressed a concern that Mr Bradbury may intend to take his own life. Paramedics attended Mr Bradbury's home, arriving at 15:15, and he was found with a ligature around his neck. Mr Bradbury was taken by Ambulance to the Norfolk and Norwich University Hospital, where he died on 25th August 2023.</td></tr>
<tr><td>5</td><td>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:</td></tr>
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	(brief summary of matters of concern) 1) During the course of the hearing I heard evidence from the East of England Ambulance Service Emergency Operations Centre. The evidence covered, amongst other things, how 999 calls to the Emergency Operations Centre are triaged. The evidence was that the triage process consists of the caller being asked a series of scripted questions based on the patient's presenting condition and symptoms. The triage is undertaken using the Medical Priority Dispatch System (MPDS) triage system, which is one of two mandated for use by NHS England for Ambulance Services, both of which are operated by non-clinically trained Call handlers. In terms of call codings, the evidence I heard was that these are defined by the Emergency Call Prioritisation Advisory Group (ECPAG). The evidence indicated that the purpose of ECPAG is to advise on issues of ambulance call prioritisation and to recommend which codes from ambulance triage systems should receive a Category 1-5 response based on clinical evidence. 2) In the case of Mr Bradbury, a 999 call was made by a member of staff at the local Drug and Alcohol Service. Amongst other things, the caller informed the call handler that that Mr Bradbury was not eating, not drinking, was dehydrated and that was using words which suggested he was catatonic. The caller confirmed that he was suffering from a number mental health conditions (including anxiety, depression, borderline personality disorder, autism, PTSD and ADHD). The caller also expressed concern that Mr Bradbury may have a plan to end his life, that he "would have taken illicit substances" and is at a significant risk of overdose. 3) The evidence I heard at inquest was that the call was coded at 25-C-1, which was as a Category 3 call. The evidence is that the call was audited and that the Quality Assurer confirmed the correct set of questions had been asked, the 25-C-1 code was correct and the Category 3 prioritisation was correct. 4) I heard oral evidence that: 25-C codes refer to patients with altered levels of consciousness; Code 25-C-1 (which results to a Category 3 prioritisation) refers to patients with an altered level of consciousness and a history of mental illness; Other subsets of Code 25-C exist, including 25-C-2 which refers to patients with an altered level of consciousness who have ingested substances; and that Code 25-C-2 would result to a Category 2 prioritisation. 5) The evidence I heard was that although Mr Bradbury had ingested substances which might have resulted in a 25-C-2 coding (and therefore at Category 2 prioritisation for an ambulance), given that he also had a history of mental illness he was coded as 25-C-1 (and therefore a Category 3 priority) because the the system does not allow for consideration of Codes 25-C-2, 25-C-3 etc if it had determined a 25-C-1 code based on the information provided. 6) The operation of this system as described in the evidence I heard could result in patients who might otherwise warrant a category 2 prioritisation being prioritised as Category 3 and therefore wait longer for an ambulance to attend. Patients with a history of mental illness would appear to fall within this group.
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 December 19, 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 ▪ [redacted] – Mother ▪ [redacted], One Pump Court Chambers – Legal Representative for the Family ▪ East of England Ambulance Service Trust I have also sent it to: ▪ Department of Health ▪ Care Quality Commission (CQC) ▪ Health Services Safety Investigations Body (HSSIB) ▪ Healthwatch Norfolk ▪ NHS ENGLAND & NHS IMPROVEMENT who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 24/10/2024** **Christopher LEACH** **Assistant Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH