	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted], **Chief Executive Officer South East Coast Ambulance Service NHS Foundation Trust** **2** **NHS England & NHS Improvement**
1	**CORONER** I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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 04 October 2023 I commenced an investigation into the death of Joel Phillip COLK aged 37. The investigation concluded at the end of the inquest on 12 November 2024. The conclusion of the inquest was that: Joel Phillip Colk died on 2 October 2023 at [redacted], Brighton having intentionally ingested at least 50 times more than the lowest fatal level of [redacted] with the intent of taking his own life.
4	**CIRCUMSTANCES OF THE DEATH** Joel Colk called 999 at 21:46 on 2 October 2023 and spoke with South East Coast Ambulance Service NHS Foundation Trust. Mr Colk reported that he had had ingested 50g of [redacted] and provided his mobile phone number and address. His call was triaged using the NHS Pathways system which resulted as a category 3 disposition for ambulance attendance. An ambulance attended him at 22:47 after the call was upgraded to category 2 at 22:28 as it had not been reviewed by a clinician in accordance with South East Coast Ambulance Service NHS Foundation Trust policy that the call be reviewed within 40 minutes. On attendance Mr Colk was in cardiac arrest and sadly despite the best efforts of clinicians he died at his home address.

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: The Court heard that when a call is made to 999 that the call is categorised using NHS Pathways and that all overdoses would be in the same classification resulting in the same disposition and response category. The system does not differentiate between types of, severity of or the drugs/chemicals reported as being the cause of the overdose. The system also does not differentiate call classification taking into account the amount reported as ingested, the timing of ingestion or the patient's weight. The Court heard that all of these factors can impact on the time in which care needs to be rendered to prevent death. The example given to the Court was that someone who had taken a relatively small paracetamol that would be unlikely to cause harm would, using Pathways, have the same resultant disposition as someone who had ingested a significant amount of a known lethal chemical. Secondly, the Court heard that in the case of [redacted] ingestion that treatment is only effective if medications are administered before the patient suffers a cardiac arrest. This likely will occur incredibly rapidly and is a known effect of the chemical. The Pathways system does not reflect the time sensitive nature for an effective response when it is known that [redacted] has been ingested and would not create a higher disposition requiring more urgent attendance than category 3. The Court was also told that clinicians do not carry on any Ambulances within South East Coast Ambulance Service NHS Foundation Trust Methylene Blue which is the antidote to [redacted] ingestion as this is not within national guidance. I heard that in some areas there are ongoing trials for some areas that this is on board vehicles within the HART (Hazardous Area Response Team). Therefore in this area the treatment is only available when a patient reaches an acute hospital with an A&E department and the evidence was that often patients enter cardiac arrest before this occurs.
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 January 08, 2025. 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 Mr Colk** **Sussex Police** **Sussex Partnership NHS Foundation Trust** **I have also sent a copy to the National Ambulance Resilience Unit who I consider may find this 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: 13/11/2024 J. Andrews Joanne ANDREWS Area Coroner for West Sussex, Brighton and Hove