Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England**
1	**CORONER** I am Robert SIMPSON, HM Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 17 January 2024 I commenced an investigation into the death of Nicholas Paul MURPHY aged 48. The investigation concluded at the end of the inquest on 28 July 2025. The conclusion of the inquest was that: On the 9th January 2024 Nicholas Paul Murphy was found deceased at his home address in Hurstbourne Place, Southampton. He was last seen on the 29th December 2023 when the ambulance service attended his address and he reported that he had taken an overdose. He declined to go to hospital and refused further assessment after which the ambulance staff left.
4	**CIRCUMSTANCES OF THE DEATH** Nicholas had struggled with mental health and addiction difficulties for a long time. He reported worsening mental health in 2023 which was impacted by antisocial behaviour around the area of his property and financial difficulties. On the 29th December 2023 he sent an email at 3.09am saying that he had taken an overdose and, at some point, posted a message on Facebook saying that he was attempting to overdose. The post was seen by his family who called 999 and reported this to the police. They were directed to request an ambulance which they did. An ambulance attended Nicholas and the crew were allowed into the property just after 6.30am. He reported to the ambulance crew that he had taken an overdose of [redacted] at 0.30am. The crew completed physical observations which revealed normal cardiovascular and respiratory functions. He did not display any overt signs of having taken an [redacted] overdose. Nicholas then withdrew his consent for further assessment and required the ambulance crew to leave. Nicholas was assessed as having mental capacity to make this decision and the crew left the property. The electronic Patient Clinical Report completed by the crew gave an accurate account of these events. However on the call log completed by the ambulance crew the outcome was given as 'Advice only'. The police contacted the ambulance service later on the 29th December to ask for an update and were advised that the patient had been seen and left at home. The police asked if there were any further concerns and were told that there was nothing to indicate that the

	attending crew had any concerns. I heard evidence that the police may have visited Nicholas had they been informed of the full circumstances of the crew's attendance. I also heard evidence that the outcome or disposition codes available for the ambulance crew on the call log are nationally mandated. It is these logs that are readily available to staff in the ambulance service contact centre. The available outcome codes do not include one that states 'Patient refused treatment/declined transfer to hospital' or anything similar. In order to access the fuller information the ambulance call centre operator would have to enter more detailed records than those available on the face of the call log. They are under pressure at work and therefore there is a risk that this might not be done as was likely to be the case here. Nicholas was found deceased in his flat on the 9th January 2024 after a further concern for his welfare was raised with the police. He had taken an overdose of [redacted] It was not possible to establish exactly when Nicholas took the overdose.
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: (brief summary of matters of concern) From the evidence I heard I am concerned that information critical to safeguarding and proper decision making may be missed, as it was in this case, given that the outcome codes do not include one that reveals the patient refused treatment. I am also concerned that the outcome of 'advice given' can give a very misleading impression of events when used in these type of circumstances.
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 the 17th October 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 Nicholas Murphy** **South Central Ambulance Service** I have also sent it to **Hampshire Police** 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: 21/08/2025**  **Robert SIMPSON** **HM Assistant Coroner for** **Hampshire, Portsmouth and Southampton**