HEATH WESTERMAN
H.M. ASSISTANT CORONER

FOR SHROPSHIRE,
TELFORD & WREKIN AREA

H.M. Coroner's Service
Guildhall
Frankwell Quay
Shrewsbury
Shropshire SY3 8HQ

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Joint Royal Colleges Ambulance Liaison Committee 2. West Midlands Ambulance Service
1	**CORONER** I am Heath Westerman, H.M. Assistant Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 14 October 2024 I commenced an investigation into the death of Wayne AUSTIN The investigation concluded at the end of the inquest on 9 April 2026 The conclusion of the inquest was: Wayne Austin became unwell and collapsed at Shrewsbury Probation office on 10 October 2024. Cardiopulmonary resuscitation was administered and West Midland Ambulance Service attended promptly. They began advanced life support which included the administration of Naloxone, a reversing agent used to deal with possible consumption of illicit drugs. He was then transferred to the emergency department of The Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, Shropshire where he died as the result of combined buprenorphine and alcohol toxicity. Drug and alcohol related.
4	**CIRCUMSTANCES OF THE DEATH** Wayne Austin attended a meeting with his probation officer on 10 October 2024. He was asked if he had consumed any illicit drugs which he denied but confirmed he had drunk some cider. He collapsed and CPR was undertaken and WMAS called. Two ambulances attended and paramedics were informed by an unknown female outside that Wayne had earlier consumed crack cocaine. WMAS paramedics therefore began ALS and sought guidance from the JRCALC app on Naloxone administration. They found the guidance confusing and experienced difficulties identifying and accessing the correct guidance and so opened the first available tab 'Dosage table: IV/IO - Respiratory arrest/depression' which confirms an initial dose of 400mg then further doses of 400mg every three minutes until a maximum of 4000mg delivered. The paramedics provided a first dose of 400mg at 14.45 with further 400mg doses at 14.50, 14.55, 15.00 and 15.05 when a return of

	spontaneous circulation was achieved and medication was paused. No further Naloxone was administered and Wayne was transferred to The Royal Shrewsbury Hospital. They could not comply with administrating doses every three minutes due to other competing tasks such as continuing with ALS, administering oxygen, adrenaline and sodium chloride. The paramedics did not open and apply the correct tab, the JRCALC app has five tabs for Naloxone, the fourth tab being the appropriate tab in the circumstances ' Dosage table: IV/IO Cardiac arrest (where opioid toxicity is the likely cause) this confirms an initial dose of 400mg then further doses of 800mg every minute until a maximum of 20,000mg delivered.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) Difficulties in locating the appropriate tab for cardiac arrest (where opioid toxicity is the likely cause) on the JRCALC app for Naloxone meant it was missed and not applied (2) Inability of attending paramedics to comply with the guidelines for Respiratory arrest/depression due to other competing tasks and therefore certainly a complete inability to comply with the guidelines for cardiac arrest (where opioid toxicity is the likely cause) making them potentially unrealistic. (3) WMAS ambulances only carry a box of 10 Naloxone 400mg vials per ambulance which means that one ambulance attending a situation such as Wayne's would be insufficient to deal with the circumstances, as would two ambulances. It would mean that three ambulances are required to comply with cardiac arrest (where opioid toxicity is the likely cause).
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 5 June 2026. 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 of the deceased. 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	[redacted] Heath Westerman H.M. Assistant Coroner Shropshire, Telford & Wrekin 10 April 2026

Send to: coronersreports@dhsc.gov.uk