Professor Paul MARKS
Senior Coroner for East Riding of Yorkshire and Kingston upon Hull

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS • **THIS REPORT IS BEING SENT TO:** Dr. David Macklin, Executive Director of Operations, Yorkshire Ambulance Service;
1	**CORONER** I am Professor Paul MARKS, Senior Coroner for East Riding of Yorkshire and Kingston upon Hull
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29/07/2014 I commenced an investigation into the death of Sally Elizabeth Mays aged 22 years. The investigation concluded at the end of the inquest on 23 October 2015. A Narrative Conclusion was returned. Sally Elizabeth MAYS was born on the 22nd January 1992 in Kingston upon Hull and died on the 25th July 2014 at Apartment 4, 1 Derringham Court, 2a Ampleforth Grove, Kingston upon Hull. The medical cause of death was: 1a) Mechanical asphyxia in combination with an overdose of Codeine and Nitrazepam. Miss MAYS had long standing psychiatric problems and was diagnosed with Borderline Personality Disorder. In the last few days of her life her self-harming, risk taking and suicidal ideation increased. She was associated with the Crisis Team on two occasions on the 25th July 2014 and whilst the first association did not result in inpatient admission, this had no causative effect on her subsequent death. In her second association with the Crisis Team on the afternoon of the 25th July 2014, she was inappropriately assessed, not treated with appropriate respect or dignity, was not reassessed after being restrained as she should have been or after showing increasingly worrying self-harming behaviour. Had admission occurred after her initial assessment or following the further two missed opportunties, she would have survived and not died when she did. The failure to admit her to an inpatient psychiatric bed constitutes neglect and this neglect bears a direct causal relationship to her death later that evening. A further missed opportunity to save her life probably presented itself when she was associated with the Ambulance Service and her call was not categorised appropriately and to compound this, a delay of 69 minutes over and above the intended 30 minutes arrival of the ambulance occurred. A situation in which an overdose had been taken alone was intensified by Miss MAYS placing a plastic bag over her head. Whilst her actions undoubtedly caused her death, her intentions remain unknown.

4	**CIRCUMSTANCES OF THE DEATH** SEE ABOVE
5	**<u>CORONER'S CONCERNS</u>** 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. – The system employed by the Yorkshire Ambulance Service NHS Trust (YAS) to assess phone calls and the dispatch of Paramedics is based on a set of Protocols known as the Advanced Medical Priority Dispatch System (AMPDS). It is used to manage all emergency calls within the Emergency Operations Centre (EOC). This system is used by other Ambulance Trusts both in the United Kingdom and internationally and is licensed by the International Academy of Emergency Dispatch (IAED). The YAS Trust produced a Serious Incident Report following the death of Miss Mays and found that the Emergency Medical Dispatcher (EMD) incorrectly chose Protocol 25 for Miss Mays' call. This Protocol is used for managing psychiatric/suicide incidents whereas Protocol 23 should have been employed as this deals with overdose and has in fact got appropriate questions within the algorithm that deal with the timing, quantity and type of agent taken. There is also provision in Protocol 25, should it be initially chosen, for the EMD to change to Protocol 23 if it becomes apparent that an overdose has been taken. Evidence was heard at Inquest that there is no Protocol to establish whether the caller or another informant has contacted the EOC. Importantly, if it is the caller who has contacted the EOC, there is no rubric to determine whether the caller is *alone* or in company. The EMD will need to keep the caller on line if they are alone as they could lapse into unconsciousness due to the effects of the overdose. If this occurs there should be an upgrade in the priority of the call which currently is allocated Green 2 status to a Red status, lest the caller succumbs whilst waiting the arrival of an ambulance. Evidence was heard that in these circumstances, if the caller is alone not only should they be kept on the line but also a Red priority should be accorded them rather than the current Green 2 priority. On the basis of the evidence heard I believe that these changes should be implemented both locally and nationally to prevent similar tragedies occurring in future.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 31 December 2015. 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, namely: • Mr. & Mrs. Mays; • Ms. B. Dolan of Sergeant's Inn Chambers representing the family; • Mr. M. Rawlinson of DAC Beachcroft LLP representing Humber NHS Foundation Trust; • Ms. A. Combes, representing Humberside Police Constabulary; • Ms. J. White, University of Hull; • Mr. N. Smart of Capstick Solicitors LLP representing the Yorkshire Ambulance Trust; • Mr. P. McKee, Charge Nurse employed by Humber NHS Foundation Trust; • Miss G. Pearson, Specialist Nurse employed by Humber NHS Foundation Trust. I have also sent it to others who may find it useful or of interest. • Dr. Clifford Mann, President of the Royal College of Emergency Medicine, London • Dr. Jason Payne-James, President of the Faculty of Forensic & Legal Medicine, London • Mr. David Behan, Chief Executive, Care Quality Commission 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	Dated 05 November 2015 Signature_____ Senior Coroner for East Riding of Yorkshire and Kingston upon Hull

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