	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Department of Health** Ministerial Correspondence and Public Enquiries Unit Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Tweddle, Senior Coroner, for the coroner area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 29th November 2013 I commenced an investigation into the death of Gary William Million. The investigation concluded at the end of the inquest on 24th July 2014.. The conclusion of the inquest was natural causes
4	**CIRCUMSTANCES OF THE DEATH** Mr Gary William Million (the deceased) telephoned 111 at 23:41pm on 23rd November 2013. The recording of the phone call shows that the deceased was not able to provide full and clear information about his name and location and the state of his health but not long into the call, the deceased went silent and for a number of minutes thereafter, whilst the call remained "live" there was no further response from the deceased to the call handler. The 111 system in the area in which the deceased lived is administered by the North East Ambulance Trust which also provides blue light emergency ambulance cover in the same area. At 23:46pm the 111 call was transferred to A&E Ambulance dispatch and was prioritised by the 111 call handler as an "R1 Emergency" with the expectation therefore that the ambulance would respond within eight minutes. At the time that the Ambulance was dispatched neither the Ambulance Service nor the 111 call handler had a full and clear address for the deceased's location to which the ambulance crew (and a rapid response paramedic) would attend. Ambulance dispatch staff/111 staff made efforts to try and obtain an address for the deceased with various external agencies. At 00:03 hrs the control room duty manager contacted British Telecommunications and spoke to an operator and asked the BT staff member to disclose the patient's address. Correctly describing the originating call to be on the 111 system, the control room duty manager's request to BT was declined on the basis that this was not an emergency and not being an emergency BT was not obliged or authorised to disclose that sensitive information. Ambulance dispatch staff/111 staff made further efforts to try and find someone able to provide an address for the deceased without success until at 00:58hrs the control duty manager contacted BT for a second time and coincidentally spoke to the same call

	handler who had dealt with the original request. Upon receipt of further information given by the call centre duty manager, the BT call handler disclosed the address at 00:59hrs. At 01:00hrs the dispatch team advised the ambulance to attend an address, but gave the wrong address. At 01:10 hrs the ambulance crew attended the correct address and found the deceased.
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. The North East Ambulance Service Trust has carried out some system changes but more in this regard needs to be done. 2. BT's evidence was that they have given further advice and information to blue light service providers (namely Fire, Police, Ambulance, Coastguard) but as they do not know of the identity of all 111 providers it is very possible that other 111 providers may not understand the limitations of the BT service for disclosing data sensitive information and therefore, so that this issue can be considered and lessons learnt therefrom the Department of Health ought to consider sharing this information with all other 111 service providers throughout the country to reduce the risk of similar fatalities in the future. A copy of the full Regulation 28 report addressed to North East Ambulance Service Trust is attached.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 23rd September 2014. 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] British Telecom North East Ambulance Service Trust Ward Hadaway 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	**29th July 2014** **……..** **ANDREW TWEDDLE LLB** **H M SENIOR CORONER** **COUNTY DURHAM AND DARLINGTON**