	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Yorkshire Ambulance Service.**
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 22nd August 2014 I commenced an investigation into the deaths of Grant Thomas Benson, age 21 and Gordon Nicky Davidson, age 26. The investigation concluded at the end of the inquest on 18th March 2015. The conclusion of the inquest was Road Traffic Collision. Gordon N Davidson's cause of death was given as 1a) Traumatic Injuries related to a Road Traffic Accident and Grant T Benson's cause of death was given as 1a) Immediate Effects of Fire related to a Road Traffic Accident.
4	**CIRCUMSTANCES OF THE DEATH** Both deceased were travelling in a motor vehicle which crashed and hit a tree. The passenger died either at the time of the collision or soon thereafter. The driver survived the initial impact and died in the ensuing fire.
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. – Between the time of the impact and him being incapable of further speech the driver had a conversation with an Ambulance Control call handler with a view to securing the attendance of the Emergency Services. This call lasted for several minutes and it is clear from listening to the recording how frantic the driver became as the fire began and took hold. The driver gave quite an accurate description of his approximate location to the call handler but the call handler was unable at any time during the call to accurately locate the whereabouts of the incident. Technological information given by GPS gave an inaccurate location for the incident. The emergency call was routed to Yorkshire Ambulance Service rather than to North East Ambulance Service which would have been based in Newcastle Upon Tyne. The call handler with Yorkshire ambulance Service was based in Wakefield. She had no personal knowledge of the area. Despite having a map in front of her and the assistance of two other members of staff looking over her shoulder and trying to assist it was not possible for an ambulance to be dispatched. The call handler in evidence said that she repeated certain key information to the caller but that is not recorded. She gave evidence that she would have covered the microphone to speak to colleagues in trying to locate the incident. Her evidence was inconsistent. It is accepted in evidence that an option might have been to have sought further and urgent advice from a more local agency, the North East Ambulance Trust or possibly Durham Police or Durham and Darlington Fire Rescue Service. Evidence was given that it is not possible to transfer responsibility for calls from one emergency service to another and the only means of further communication would be by telephone. The

	evidence was clear that in cross boundary area situations there are inadequate systems in place to secure the best possible response to an incident. It is not possible for one ambulance service to dispatch an ambulance from another ambulance service. Evidence was given that a suitable ambulance had been identified to be sent to this incident based at Richmond North Yorkshire with an estimated journey time of 28 minutes. There was an ambulance station situated in Barnard Castle (and incidentally a Police Station and Fire Station) which is only some 5 minutes or so travelling time away from the incident location. Because of the difficulties in establishing an exact location, at no time did Yorkshire Ambulance have sufficient information to despatch an ambulance. Emergency services only attended the scene of the incident once a further call had been made to the Emergency Services by a member of the public. The evidence in this case was that even if the local Fire Brigade had been promptly summond, an appropriate appliance would not have reached the incident scene sufficiently quickly to have changed the outcome i.e. the death of the driver. The evidence however, reveals system shortcomings which may in other circumstances lead to avoidable deaths taking place and therefore a review by the Emergency Services of a joined up approach could be particularly useful, in addition to a comprehensive review of call handling procedures in difficult circumstances such as these.
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 14th May 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, Yorkshire Ambulance Service. I have also sent it to [redacted], [redacted] Durham Constabulary, County Durham and Darlington Fire Brigade and North East Ambulance Service who may find it useful or of interest. 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	**[DATE]** **[SIGNED BY CORONER]**