Tony Brown LLM
H M Senior Coroner
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Yvonne Ormston** **Chief Executive NEAS NHS Foundation Trust** **Bernicia House, The Waterfront** **Goldcrest Way, Newburn Riverside** **Newcastle-upon-Tyne, NE15 8NY** [redacted] **Chief Clinical Officer** **NHS Northumberland Clinical Commissioning Group** **County Hall, Morpeth, NE61 2EF**
1	**CORONER** I am Tony Brown, senior coroner, for the coroner area of North Northumberland
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 30th January 2015 I commenced an investigation into the death of Kyle William Lowes aged 16 years. The investigation concluded at the end of the Inquest on 17th August 2016 with the following narrative conclusion:- 'Kyle William Lowes was riding his motor scooter at North Road, Berwick-upon-Tweed at approximately 10.00 p.m. on 30.01.15 when his motor scooter collided with a Vauxhall Astra motor vehicle being driven directly across Kyle's path when turning right from the opposing carriageway. Emergency services were contacted at 10.02 p.m. by a witness to the collision. An ambulance crew was not called by ambulance control from the nearby Berwick ambulance station because they had been stood down for their meal break at 10.00 p.m. An alternative paramedic was directed from Wooler who attended at 10.28 p.m., followed very shortly after by the Berwick crew who had on request from the Wooler paramedic, agreed to come off their meal break. Despite determined attempts at resuscitation Kyle could not be revived and his death was pronounced at 10.56 p.m. by paramedic [redacted]. The Forensic Pathologist [redacted] found that the medical cause of Kyle's death was due to a blunt head injury and gave his view as Pathologist though not as a Practising Specialist who treats patients, that the severity of Kyle's injuries and the distance from a major trauma hospital meant that it was unlikely that the fatal outcome for Kyle would have been any different had the paramedics been able to arrive sooner.

4	**CIRCUMSTANCES OF THE DEATH** The incident was reported to North East Ambulance Emergency Control Centre at 10.00 p.m. on 30.01.15. Two minutes earlier the Berwick paramedic team day shift had gone off duty because there are only two ambulance crews provided between 10.00 a.m. and 10.00 p.m. and one overnight crew operating 'mid shift' between 6.30 p.m. and 6.30 a.m. who were instructed to take their statutory meal break. They could not therefore be contacted by ambulance control. This resulted in a travelling time of 26 minutes to the incident from the nearest paramedic resource (Wooler) instead of 3 minutes from Berwick-upon-Tweed. The practical difficulties encountered with Kyle Lowes' emergency attendance were that Kyle required urgent advanced life support for the restoration of his breathing and a period of 26 minutes while waiting for a first responder from Wooler might have affected his chances of survival.
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. – The new Northumbria Specialist Emergency Care Hospital now make better provision for the County of Northumberland as a whole, but extends still further the long journey times for emergency care from Berwick-upon-Tweed, a sizeable border town, with a population which trebles throughout the tourist season because of its location as a holiday destination. By having only one paramedic crew after 10.00 p.m., if that crew is on a meal break, or as they regularly need to do, attend duties in another part of the County, risk is created to the population of Berwick-upon-Tweed by significant delays in attending life threatening incidents after 10.00 p.m., as there was in Kyle's case. I was informed at the Inquest that NEAS are introducing a scheme whereby paramedic crews will be asked at the start of each shift whether they are willing to be contacted for emergency calls during their meal breaks, which might go some way towards helping to resolve the concerns but does not provide any certainty while resting only on the goodwill and agreement of ambulance personnel concerned. This proposal for response to emergency calls during meal breaks would also not address the risk of delayed response times when the single Berwick ambulance crew after 10.00 p.m. is called upon for duties out of the area.
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. At the Inquest I was informed that care would be provided in a different way in future, due to changes in NICE Guidelines but I remain concerned about the underlying question of service provision, and believe that you should take some action to address this. This report is addressed to North East Ambulance Service as an organisation having the power to take some action and to the Clinical Commissioning Group, because I was informed at the Inquest that the Group enable, commission or fund the provision of the services and NEAS stated in evidence that they are dependent upon services being commissioned by the Group.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th October 2016. 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] Direct Line Group and to [redacted] Local Safeguarding Children Board. I have also sent it to Councillor [redacted] Leader of Northumberland County Council, Anne Marie Trevelyan MP and Right Honourable Jeremy Hunt MP, 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 26th August 2016**  **TONY BROWN** **HM Senior Coroner for North Northumberland**