Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: -** **Ms Yvonne Ormston** **Chief Executive** **North East Ambulance Service NHS Foundation Trust**
1	**CORONER** I am Derek Winter DL, Senior Coroner for the City of Sunderland
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 28th December 2016 Mr Darren James Powney, aged 37 years, died at his home. A Jury concluded the 3-day Inquest as part of my investigation on 8th November 2017 recording a conclusion of Natural Causes. The Cause of Death following Post-Mortem Examination was: - Ia Pulmonary Embolus
4	**CIRCUMSTANCES OF THE DEATH** Darren James Powney, known in the Inquest as Darren, aged 37 years, called 999 from his home address on Wednesday 28th December 2016 at 06:52 requesting an ambulance. Darren complained predominantly of chest pains, and upon questioning also of breathlessness. Darren suggested to the call handler that he thought he was having a heart attack. The call lasted 5 minutes 43 seconds, and concluded with the call handler telling Darren that a blue-light emergency ambulance had been arranged, and further instructing Darren to call back on 999 should he have further concerns, or if his condition deteriorated. The call was graded as a Red 2 response. The normal response time for this category of call, made by Darren, is 8 minutes. North East Ambulance Service (NEAS) held information about Darren based upon previous encounters with him. This information, variously termed "flags" or "markers", prompted NEAS staff to seek Police assistance in the matter. Those markers were "no lone workers, mh/substance and alcohol withdrawal, aggressive/unpredictable behaviour, large dog at address, weapon claw hammer".

Civic Centre, Burdon Road,Sunderland, SR2 7DN
Tel 0191 5617843 \| Fax 0191 5537803 \| DX 60729 Sunderland
www.sunderland.gov.uk/coroner

Northumbria Police and NEAS response to the call and attendance at Darren's home were governed by a protocol dated August 2016.

A number of requests were made by the NEAS to Northumbria Police to accompany them to the scene in order to show a presence to prevent, rather than react to, any disturbance. The Police generated an incident log. FWIN168. The Police graded this as a Grade 5 low priority and it remained the same throughout. The requests for simultaneous deployment were declined by Northumbria Police, who advised NEAS that they should attend Darren and then call for assistance should it be required as per protocol.

Given the delay, the Police further risk-assessed the situation and as a result made the decision to allocate Police Officers to attend the incident. This was communicated to NEAS at 08:02 hrs. A Police Officer drove past the ambulance tasked to attend Darren parked up at a rendezvous point about half a mile from Darren's address, and confirmed verbally with the ambulance crew that they had been allocated to the same incident. The Police Officer arrived at Darren's address at 08:14 hours and found Darren slumped in an arm chair. Paramedics then entered the property. Darren was in his arm chair with his phone on a table beside him on charge showing a missed call at 07:07 hrs from NEAS. Darren was unresponsive and had no pulse. Advanced Life Support was undertaken without success.

Home Office Forensic Pathologist and a Consultant in Emergency Medicine were asked to consider Darren's prospects of survivability had the ambulance arrived in 8 minutes. concluded that the large Pulmonary Embolus had occluded both main pulmonary arteries, and in his opinion even if the paramedics had been in attendance at the time it occurred, it is far more likely than not that Darren would have died in any event. agreed. Critical, in the opinion of was the call made at 07:07 hrs by the NEAS to Darren's mobile, which was 15 minutes after his first contact by his 999 call (06:52 hrs). That call at 07:07 hrs went unanswered despite the close proximity of Darren's phone to him in the armchair. is of the view that Darren was incapacitated at this point. took the view that Darren was probably dead.

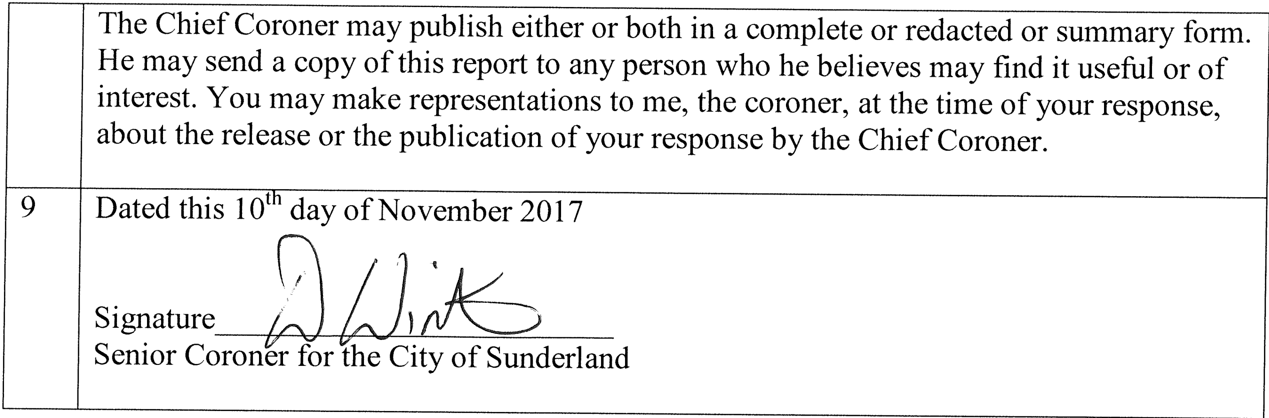
The Police staff gave consistent evidence that the August 2016 protocol was clear that, if there was a medical issue, an ambulance would be expected to attend the scene without the presence of police and that records of previous incidents would not necessarily justify the sending of a police resource if such data was historical and there was no evidence of violence in the current reported matter. The Police did their THRIVE assessment that the priority was low (THRIVE: threat, harm, risk, investigation, vulnerability and engagement).

NEAS did what was described as a dynamic risk assessment in the vehicle at the rendezvous point essentially based on the markers but not at the scene.

Historically, Darren had called for an ambulance on 21 occasions from 6th May 2016 to 28th December 2016, and ambulance crews had gone without police even after requests for police assistance. For example, on 22nd August, 16th September and 7th November 2016.

There was confusion regarding the level of threat presented by Darren and also how human factors influenced events. The main issue was the delay with NEAS and Northumbria Police resolving their differences, and in the meantime Darren - a Red 2 patient - remained unattended for in excess of an hour, when this was supposed to be an 8 minute response. It was only a concession by the Police because it was "getting silly", which got things moving and the standoff resolved.

5	**CORONER'S CONCERNS** Inquests are a fact finding inquiry into a person's death and it is important that lessons are learnt. The making of this report is not punitive nor is it a censure. The safety of our emergency responders is very important, and sadly they appear to be the subject of violence or the threat of it. Darren's death has highlighted the process our emergency responders now have to go through. I heard evidence about the reviews of procedures undertaken since Darren's death, but I still have concerns. I was dismayed to hear about the confusion that arose, and that some NEAS staff were still not aware of the Protocol dated August 2016. It appeared that the dynamic risk assessment undertaken did not facilitate ambulance crews requesting further information or clarification, as the markers can unintentionally build a picture about an individual. In Darren's case I was surprised there was not a bespoke policy for him given that he had called 21 times since May 2016. I heard evidence about the proposed escalation to senior managers should such confusion reoccur, but with an 8 minute response time that escalation must be rapid. Although a lot of work has been done, I am concerned there appears to me more to be done, implemented and trained upon sooner, rather than later. Nearly a year on and, although the new protocol may be on the cusp of being agreed, there is nothing firm enough in my view in place with a clear training programme. In any event I hope my Report will give the necessary impetus to conclusion and implementation. For Darren the confusion, which led to delay, made no difference, but for someone else it might. As this issue may have more than implications locally I have copied in others who may have an interest.
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 11th January 2018. 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: - • Family • Secretary of State for Health • Chair of the National Police Chiefs' Council • Chief Constable of Northumbria Police and his Counsel/Solicitors • Head of Risk – Quality and Safety, North East Ambulance Service NHS Foundation Trust and Trust's Counsel/Solicitors • Care Quality Commission (CQC) 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 this 10th day of November 2017 Signature________________________ Senior Coroner for the City of Sunderland