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 (NEAS)**
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 10th June 2017 Mr Raymond Henry Davidson (Raymond), aged 69 years, died at his home address. The Inquest, as part of my Investigation, concluded on 27th February 2018, when I recorded a conclusion of Natural Causes Contributed by Neglect. The Cause of Death following Post-Mortem Examination was: - Ia Large Bowel Voluvlus
4	**CIRCUMSTANCES OF THE DEATH** On the 9th June 2017 at 15:19, NEAS received a call into 111 from a gentleman to highlight concerns for his brother. At 15:39, the 111 clinician triaged to a GP contact within 2 hours. On reviewing this call, it was found that this decision was not as robust as it ought to have been. At 17:45 an Urgent booking was received by ambulance control to arrange an Urgent ambulance within 2 hours to transport Raymond into Queen Elizabeth Hospital. No ambulance attended. At 20:11 the first welfare call was completed with no worsening symptoms described. This was followed with further welfare calls at 21:54, 23:04 and 00:05 with no worsening symptoms described. At 01:05 the Call handler called a clinician to highlight the fifth welfare call was about to be carried out, and advice to upgrade the call was given. At 01:07 the case was therefore upgraded and prioritised as a G2 emergency response (within 30 minutes). No Ambulance attended. Raymond's brother rang 999 at 02:02 as Raymond had stopped breathing.

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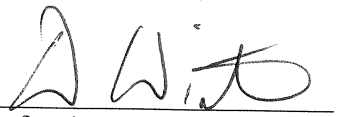
	The case was upgraded to a R1 emergency response for within 8 minutes and CPR instructions given. The Rapid Response arrived on scene at 02:10, but Raymond had sadly passed away before the arrival of the crew.
5	**CORONER'S CONCERNS** I heard evidence that: - • the recruitment/retention of staff had improved; and • welfare calls triggered earlier clinician involvement than previously; and • although there were several other initiatives under way, operational shortages were ongoing. Raymond's death highlighted resource issues. There was only so much NEAS could do when they simply did not have enough ambulances to send. At times demand was greater than the resources NEAS had available. The effect of urgent cases being interposed put back those cases appearing to be less urgent. In this case: - • 10 hours 51 minutes elapsed from the original 111 call; • 8 hours and 29 minutes after the urgent categorisation; and • 1 hour 3 minutes after the case was prioritised as a G2 response. This is the third such report about the same issue that I have written in recent months as I consider that there is a risk of future deaths. An urgent review of resources and their application is needed. Finally from the evidence, there was frequent telephone contact made, but this was not with the patient directly, which may have impacted on the less than robust initial clinical review of Raymond's condition.
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 27th April 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: - • Family • Secretary of State for Health • Head of Risk – Quality and Safety, North East Ambulance Service NHS Foundation Trust and Trust's 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 27th day of February 2018 Signature  Senior Coroner for the City of Sunderland