	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive,** **North East Ambulance Trust, Ambulance Headquarters, Berncia House, The Waterfront, Goldcrest Way, Newburn Riverside, Newcastle upon Tyne NE15 8NY**
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. Once the 111 operator had failed to obtain detailed information about the callers location, there was a delay of some minutes before referring the matter to the Ambulance Trust and for the dispatch of an ambulance. 2. No 111/ambulance dispatch staff knew of or had been trained about the correct procedure to be adopted when trying to locate a potentially seriously ill patient when they had incomplete information as to that persons whereabouts. In short, they did not know how to obtain the callers address. Despite the considerable and well intentioned efforts of a number of people working in the call centre, these individuals failed to locate the deceased's home address and as a result there was an inordinate delay before the ambulance crew were able to attend the deceased's property. 3. When the ambulance service duty manager spoke to BT, that individual did not fully explain the nature and reason for the enquiry with the result that the BT operator was not seized of all relevant information with which he could make a fully reasoned decision as to whether to exercise his discretion or not to release the deceased's home address to the caller. 4. A detailed investigation that was undertaken by North East Ambulance Trust is upon closer examination, in places lacking depth and incisiveness. 5. New revised North East Ambulance Service Trust protocols which are undated, and which were produced to the Senior Coroner only on the morning of the Inquest being resumed, do not deal with the problems identified in this case even though they were designed to address them. 6. The deceased died in November 2013 and within a day or two of the death being reported, it was clear that the circumstances of the death highlighted serious potential systemic failures and yet, no substantive further advice was given to control room staff until February 2014. 7. Upon receipt from BT of an email in February 2014 in which BT endeavoured to address the issues raised by this death, the North East Ambulance Service Trust, copied the email to senior managers and other staff (though it is not known who exactly) to advise them of the change of procedure but other than merely forwarding the email the North East Ambulance Service Trust did not take any steps to try and ensure that this potentially life saving information was known by all people who were involved in the call handling process. No specific training on this important issue has been carried out as at the date hereof and none was planned. 8. The response to the incident by the Trust appears perfunctory and now, eight months after the death of the deceased, notwithstanding the changes made to practice and procedure by the North East Ambulance Service Trust it is clear that a clear and robust policy and practice to address this issue is not in place.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 23nd 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] Messrs Ward Hadaway British Telecom 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**