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 14th December 2016 Mr Andrew Stephen Finlay, aged 54 years, died at his home address. The Inquest, as part of my Investigation, concluded on 25th January 2018, when I recorded a conclusion of Natural Causes. The Cause of Death following Post-Mortem Examination was: - Ia Myocardial Infarction Ib Coronary Artery Thrombosis Ic Coronary Artery Atheroma II Hypertension
4	**CIRCUMSTANCES OF THE DEATH** Andrew Stephen Finlay, known in the Inquest as Andrew, aged 54 years, collapsed at his home address on 13th December 2016. Andrew's partner telephoned 999 from their home address requesting an emergency ambulance. The call was graded as a Red 2 response. The normal response time for this category of call is 8 minutes. Despite further telephone calls, it took an ambulance crew in the region of 36 minutes to arrive. Expert evidence from a Consultant in Emergency Medicine and a Consultant Cardiologist was such that delays in the despatch and arrival of an ambulance crew did not affect the outcome. It was more likely than not that Andrew would have died in any event.

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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. However, it is the 2nd such Report in recent months that I have written about the timely despatch and arrival of an ambulance crew in response to a 999 call. I heard evidence about the reviews of procedures undertaken since Andrew's death, but I still have concerns. Although the plans for the recruitment and retention of personnel and the purchase of additional vehicles were encouraging to hear evidence about, I was told there were still 32 paramedic vacancies to be filled a year on after Andrew's death. For Andrew the delay made no difference, but for someone else it might. Accordingly it is my duty to write this Report to you, particularly as it may add impetus to the improvement plan.
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 March 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 and their Solicitors • Secretary of State for Health • Head of Risk – Quality and Safety, North East Ambulance Service NHS Foundation Trust and Trust's Counsel/Solicitors • Care Quality Commission (CQC) • Healthcare Safety Investigation Branch (HSIB) 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 26th day of January 2018 Signature Senior Coroner for the City of Sunderland