	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **JRCALC** [redacted] **AACE, GG322, Metal Box Factory, 30 Great Guildford St, London SE1 0HS, and also by email.**
1	**CORONER** I am Heidi J Connor, senior coroner, for the coroner area of Berkshire.
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** I conducted an inquest into the death of Aston Neil McLean that was heard by a jury at Reading Town Hall from 11-22 November 2019. The jury concluded that the timing of the decision by ambulance staff to declare Aston deceased on scene did not cause or contribute to his death.
4	**CIRCUMSTANCES OF THE DEATH** The family asked us to refer to the deceased as Aston at the inquest. I have reflected that request in this report. In the early hours of 6 August 2014, Aston was pursued by Thames Valley Police from the scene of a suspected offence. Tragically, this resulted in a collision with an armed response vehicle at 01.56 hours that morning. Aston was trapped underneath the vehicle. An ambulance technician attended at 01.59 hours. When he got to Aston, he could see his head sticking out from under the vehicle. He was not able to assess Aston's airway. He could not see or hear any breathing. He was not able to feel a pulse on Aston's wrist. He was not able to detect any neurological response or signs of life. He concluded that Aston was dead. Aston was declared deceased at 02.05 hours. Subsequent to this, it was agreed that there was no way to lift the heavy armed response vehicle in a safe manner. The evidence of the ambulance crew was that they did not know how long it would take for the fire service to attend, nor how long it would take them to lift the vehicle off Aston. The ambulance crew who attended believed Aston had injuries incompatible with life. They assumed Aston had been under the vehicle for longer than he in fact had. It was thought that Aston had suffered an injury which was "unequivocally associated with death" – because of the car crushing down on him. When completing the Recognition of Life Extinct form ('ROLE'), the crew felt that the relevant category was that of "massive similar injuries". Subsequent evidence from the fire service (together with reconstruction videos) indicated that the fire service was likely to have been able to lift the vehicle off Aston within 4½ minutes. They were in attendance at the scene from 02.04. I instructed an independent expert in this case. He is an ICU consultant who has previously been the Clinical Director of an ambulance service and is also involved in reviewing JRCALC guidelines. The expert gave evidence that he too would have declared Aston deceased in the way that the attending crew did. He also however indicated that, if the vehicle had been lifted off Aston very soon after the collision, he may have survived. This aspect of his evidence is arguably contradictory, given that

	recognition of life extinct by an ambulance clinician can only take place where there is a condition "unequivocally associated with death". It would appear that in this scenario both the attending crew and the expert have taken into account (correctly or otherwise) a view that the vehicle could not be lifted off Aston soon enough to change the outcome.
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 could 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) I invite you to reconsider your guidelines in relation to ROLE, to clarify that this should only occur where death has already taken place, and not on the basis of either of the following assumptions: (a) Likely death at some imminent point in the future; and/or (b) Perceived difficulty in the timing of extracting a patient from a position where providing treatment is physically impossible. In this case, the decision not to lift the vehicle was based on a declaration of death in circumstances where the ambulance crew had no knowledge of how quickly the fire service would be able to lift the vehicle off Aston. Whilst the jury found that this did not cause or contribute to Aston's death, there is a risk of future deaths should a similar scenario occur. (2) The need for a wider category of injuries "unequivocally associated with death" (i.e. "massive similar injuries") makes sense, given that no list could possibly include every scenario. The current guidance makes clear that any condition in this category must be "unequivocally associated with death". In addition, the phrase "similar massive injuries" is in the same category as "hemicorporectomy". It may be that the inference from this is already sufficiently clear, but it may also be useful for you to consider making clear what level of injury is covered by the phrase "similar massive injuries". There should presumably be no doubt whatsoever that death has occurred. (3) It was clear from the evidence in this case that the crew attending did not know that the fire service had equipment which would have enabled them to lift the vehicle off Aston within a short space of time. This could clearly form an important part of key decision making at scenes like this. I invite you to consider incorporating within your guidelines the recommendation that local ambulance services should obtain relevant information from their local fire service on this point, and include this in local guidance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 16 March 2020. I, the coroner, may extend this 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 also to the legal

	representatives for Aston's mother and Aston's former partner. I have also sent a copy of this report to the following organisations (via their legal representatives where these are known): (1) South Central Ambulance Service. (2) Royal Berkshire Fire and Rescue Service. 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	**20th January 2020** **SIGNED BY CORONER**