REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Managing Director, Cleric**
1	**CORONER** I am Georgina Nolan, Senior Coroner for the coroner area of Newcastle and North Tyneside.
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** On 30th April 2022 I commenced an investigation into the death of Shiya Jonathan Barnard Collins, aged 23. The investigation concluded at the end of the inquest on 27th October 2023. The medical cause of death was 1a) Haemorrhagic hypovolaemic cardiac arrest; 1b) An incised wound to the right lower limb.
4	**CIRCUMSTANCES OF THE DEATH** Shortly after 10pm on the evening of 29th April 2022 Shiya Jonathan Barnard Collins kicked the glass panel of a door which cracked and caused a laceration to his leg. An ambulance was requested shortly before 10.30pm but the highest priority response (Category 1) was not generated. Further calls to the ambulance service were made but the computer system precluded clinicians from being able to upgrade the category of call despite information indicating that Shiya Collins was suffering significant blood loss and his clinical condition was deteriorating. The paramedic arrived 45 minutes after the first 999 call was made. By that time Shiya Collins had sustained catastrophic blood loss which caused him to suffer a cardiac arrest from which he could not be revived.
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) Seven calls were made to the North East Ambulance Service (following the initial call) indicating that Shiya Collins' condition was deteriorating. Call handlers recognised the need for clinical input in order to facilitate a possible upgrade of the ambulance response to category 1. However, the locking facility on the Cleric computer system used in the control room precluded any clinician from assessing/upgrading the call because the system was locked and unable to be accessed whilst live calls relating to the case were ongoing.
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, namely by 26th December 2023. 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: Mr Collins' family, North East Ambulance Service, Newcastle upon Tyne Hospitals NHS Trust. 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	**[DATE]** **[SIGNED BY CORONER]** **31st October 2023**