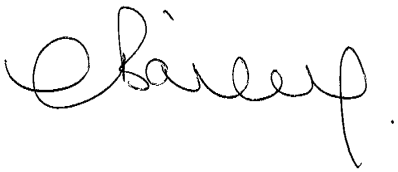
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **North East Ambulance Service NHS Foundation Trust** **Bernicia House** **Goldcrest Way** **Newburn Riverside** **Newcastle upon Tyne NE15 8NY**
1	**CORONER** I am Clare Bailey, HM Senior Coroner for Teesside & Hartlepool Coroner's Service
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 29 July 2022 I commenced an investigation into the death of John Robert TAYLOR aged 35. The investigation concluded at the end of the inquest on 07 December 2023. The conclusion of the inquest was that: John Robert Taylor took a deliberate overdose of insulin, probably on 18.07.2022, with the intention of ending his life. He contacted the emergency services for help. The ambulance arrived the following morning. There was a delay of over 13 hours in the arrival of the ambulance. John was transported to the University Hospital of North Tees. He died at the University Hospital of North Tees on 27.07.2022. Johns' death was contributed to by the delay in the arrival of the ambulance The Medical Cause of his death is: 1a. Aspiration Pneumonia 1b. Hypoglycaemic Brain injury 1c. Insulin Overdose II Morbid Obesity, Asthma, Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Mr Taylor contacted the fire brigades befriend service on 18.07.22 expressing suicidal intent and plans. The fire brigade contacted Cleveland police who is turn contacted NEAS at 1557 on that day. After 3 unsuccessful attempts to speak with Mr Taylor, contact was made at 1610 by a call handler. The matter was assessed as requiring a Category 3 response. The ambulance arrived at Mr Taylor's home at 0523 on 19.07.22, occasioning a delay of over 13 hours. The paramedic tried the door, but access could not be gained. At 0543 a request was to the police to gain entry. The police arrived on scene at 0558. When the police arrived, they noted that the door was unlocked and that the ambulances hadn't tried the handle. They gained access to the property within one minute. Care and attention were provided to Mr Taylor, and he was transported to UHNT. He died on 27.07.22.

	I instructed an independent expert who determined that the delay in the ambulance arrival contributed to Mr Taylor's death. NEAS undertook an SI report. Oral evidence was provided by a Team Leader and a Clinical Section Manager, the latter having authored the SI Report. It was clear that a comprehensive investigation had been undertaken and learning implemented. The author of the SI report was not aware that the door to the property was unlocked, and that access could have been gained over thirty minutes earlier. My concern is that this information has not been offered or elicited nor has it been reported to the SI author. This issue has therefore not been considered within the SI. A further concern is that the Family gave evidence about NEAS previously using a taxi to transport Mr Taylor to hospital on several occasions. The Clinical Section Manager said there was no policy on this and that it is in the operator's "gift". She told me there is no evidence that this option was considered on 18-19 July 2022 to transport him to hospital sooner.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. The attending paramedics had not adequately checked the door handle. It was unlocked. As a result, they waited an extra 30 minutes for the police to arrive in order to gain entry. 2. The circumstances surrounding the failure to adequately check the door handle was not offered or elicited within the internal investigation. Subsequently it was not reported to the SI author. This issue was not considered within the SI. 3. Consideration was not given to the possibility of sending a taxi to Mr Taylor so he might be conveyed to hospital quickly.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted], Chief Executive North East Ambulance Service NHS Foundation Trust Bernicia House Goldcrest Way Newburn Riverside Newcastle upon Tyne NE15 8NY 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 February 09, 2024. 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 I have also sent it to John Robert Taylor's family who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 15 December 2023**  **HM Senior Coroner for Teesside & Hartlepool Coroner's Service**