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Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY

Strictly Private and Confidential

Miss Georgina Nolan

His Majesty's Senior Coroner for Newcastle and North Tyneside

Date: 31 July 2026

Dear Miss Nolan,

In the inquest touching on the death of Ms Edie Smart – Regulation 28 Response

I am writing in my role as Chief Executive of North East Ambulance Service NHS Foundation Trust ('NEAS') and in response to the Regulation 28 report for the prevention of future deaths dated 09 June 2026 as issued by you following the inquest into the tragic death of Ms Edie Grace Smart. I am sorry that you have had to raise concerns with NEAS following the inquest and would like to take this opportunity to pass on my sincere condolences to the family of Edie.

This response will address the matters of concern raised in your Regulation 28 Report, as replicated below:

- 1. Ambulance Support Practitioners are often first on scene on an out of hospital cardiac arrest but are only trained to use i gels to secure a patient's airway under the supervision of a paramedic.**

Part (i) – Ambulance Support Practitioners ('ASP') Role

The ASP role was introduced as part of a series of changes to NEAS' workforce, which included a transition away from the Emergency Care Technician and Clinical Care Assistant roles. The purpose of such transition was to establish a trained support workforce to operate within a paramedic-led model of care.

ASPs are not registered healthcare professionals but are trained, assessed, and authorised to undertake a defined range of clinical interventions within an established scope of practice. The ASP role was formally implemented across NEAS on 01 November 2024. Since its introduction, all relevant non-registered clinical staff have undergone a process of scope-of-practice realignment, supported by additional education, training, and competency assessments, to ensure that they are

appropriately prepared to practise consistently and safely within the defined ASP scope of practice.

Part (ii) – Deployment of ASPs

NEAS' deployment model is primarily based upon ASPs working alongside registered paramedics in a supportive capacity. However, at any given time, NEAS does also deploy, on average, ten non-paramedic-led Double Crewed Ambulances ('DCA') across the North East region. These resources are staffed by two ASPs and represent approximately 7% of the Trust's total available operational resources.

The primary function of NEAS' double-ASP ambulance crews is to provide transport for patients who have already been clinically assessed by a registered healthcare professional. This includes appropriate inter-facility transfers, category 3 and 4 calls from a registered healthcare professional, and category 4 or other urgent incidents where a working impression or diagnosis has already been established, and the patient has been confirmed as only requiring basic monitoring during transport. Double-ASP ambulances are not intended to act as an ambulance resource capable of independent clinical assessment, and, by having a small number of double-ASP ambulances available to transport patients who have already been clinically assessed and do not require ongoing clinical care, this allows for paramedic-led ambulances to be kept available for other 999 calls which require clinical assessment and care.

There are however circumstances where deploying a double-ASP crew as the initial response to a category 1 ('C1') incident is both appropriate and in the patient's best interests. The NEAS deployment plan permits a non-paramedic-led DCA to be deployed as the first response to a C1 incident where there is no closer paramedic response available, provided that the crew is immediately backed up by a paramedic resource. This approach enables the closest appropriate available resource to attend, in order to provide time-critical, potentially life-saving basic interventions, including basic airway management, assisted ventilation, cardiopulmonary resuscitation, and defibrillation. Per the deployment plan, it remains expected that a paramedic resource should respond as soon as possible to provide advanced clinical assessment and interventions where required, which ASP crews, who are not registered healthcare professionals, are not able or authorised to provide.

Consequently, there will be a small number of occasions where a double-ASP crew arrives at a C1 incident before a paramedic. This does not however mean that ASPs are deployed to provide prolonged autonomous management of critically ill or injured patients requiring advanced clinical interventions. Rather, their role in these circumstances is to initiate immediate life-saving care pending the arrival of a registered paramedic. Evaluation of the deployment model has demonstrated that, where double-ASP crews require paramedic support, a paramedic resource arrives, on average, within 3.26 minutes, providing timely access to advanced clinical care, oversight, and escalation.

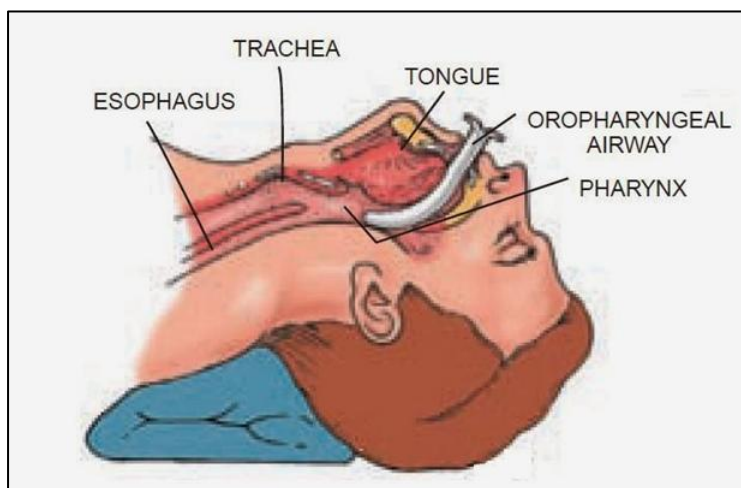
We would also suggest that it would not be accurate to characterise ASPs as often being first on scene for an out of hospital cardiac arrest. Historical NEAS data covering the period of December 2024 to May 2025 identified that, of the 19,608 C1 calls responded to by NEAS during this period, 251 involved a double-ASP response, which is approximately 1.3% of cases. Therefore, whilst the deployment model deliberately allows double-ASP crews to respond first in limited C1 cases, namely where this facilitates an earlier opportunity to deliver immediate life-saving interventions, the available data indicates that this represents a very small proportion of overall ambulance responses to C1 calls and that double-ASP crews are not often first on scene for out-of-hospital cardiac arrests.

Part (iii) – ASPs and Airway Management

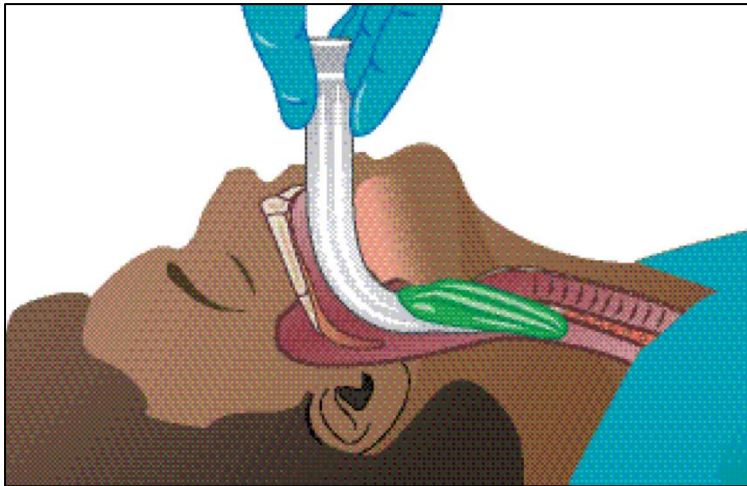
ASPs are trained and authorised to independently undertake a structured approach to basic airway management in accordance with JRCALC guidance. JRCALC is nationally issued clinical guidance, governed by the Joint Royal Colleges Ambulance Liaison Committee, that is utilised by ambulance services nationwide. This includes management techniques such as airway positioning and manoeuvres, suction, bag-valve-mask ventilation, insertion of oropharyngeal and nasopharyngeal airways, and ongoing assessment of airway patency and ventilation. These interventions enable ASPs to establish and maintain a patent airway and provide effective ventilation while awaiting, or working alongside, a registered paramedic or other healthcare professional.

An i-gel is a type of supraglottic airway device ('**SGA**') and, unlike an oropharyngeal airway ('**OPA**') or nasopharyngeal airway ('**NPA**') which are airway adjuncts authorised for insertion by ASPs and used to help maintain upper airway patency, an SGA is positioned above the laryngeal opening and is intended to provide a conduit through which the lungs can be ventilated. In practical terms, this means an SGA is situated deeper in the patient's throat than an OPA or NPA would be. Please see the below images for comparison:

OPA:



SGA:



Therefore, the use of an SGA involves additional considerations beyond those associated with the insertion of an OPA or NPA, including ensuring appropriate patient and device selection, assessment of placement, confirmation that ventilation is effective, and continued monitoring of the position and function of the device. As such, the insertion of an SGA, including i-gels, is considered an advanced airway management intervention, of which ASPs are not presently authorised to undertake independently by NEAS.

The classification of i-gel use as an advanced airway management intervention is supported by the national and UK evidence base. The AIRWAYS-2 trial, which was a large UK multicentre randomised controlled trial involving ambulance services, specifically evaluated the i-gel supraglottic airway against tracheal intubation as the initial 'advanced airway management' strategy used by paramedics in adult out-of-hospital cardiac arrests. Current Resuscitation Council UK guidance similarly describes a stepwise approach to airway management during resuscitation, progressing from basic airway techniques according to the patient's needs and the skills of the rescuer, to more advanced techniques, with SGAs forming part of the escalation in airway management.

Therefore, within this context, NEAS considers i-gel insertion to constitute an advanced airway management intervention and therefore requires its use by ASPs to take place under the supervision or direction of a registered healthcare professional. Although ASPs do receive training in the practical insertion of SGAs, safe and effective use extends beyond the physical act of device placement and requires effective assessment of the patient and their airway, selection of an appropriate airway strategy, confirmation of effective ventilation, recognition and management of any complications, ongoing reassessment, and the ability to modify or escalate the airway strategy where ventilation is ineffective.

It is important to recognise that some risks associated with airway management are not exclusive to SGAs. Ineffective ventilation, airway obstruction, gastric insufflation,

regurgitation, and aspiration may also occur during basic airway management, including bag-valve-mask ventilation. ASPs therefore are trained to recognise and manage these risks within their defined scope of practice. However, the distinction in relation to an i-gel, and SGAs more generally, is that the insertion of such devices introduces additional device-specific considerations and risks not otherwise present, including risks surrounding incorrect positioning, displacement, inadequate seal, air leak, and failure to achieve or maintain effective ventilation. Airway trauma may also occur. Apparent successful insertion of an i-gel does not, in itself, confirm that the ventilation is effective, and the patient's response, chest movements, and ventilation characteristics must be assessed and continually reassessed with waveform capnography (which is a system to monitor exhaled carbon dioxide). The wider clinical context and anticipated progression of the care following the insertion of the i-gel must also be considered, including the cause of the cardiac arrest, the availability and skills of attending personnel, the need to minimise interruptions to other time-critical interventions, and whether an alternative airway strategy is more appropriate. Failure to achieve or maintain adequate ventilation should prompt immediate reassessment and consideration of an alternative airway management strategy.

Therefore, in short, there are additional considerations and risks to a patient when inserting an SGA, which are not present when inserting an OPA or NPA.

The distinction in authorisation is therefore not based solely on whether an ASP has been taught and demonstrated competence in the technique of inserting an i-gel. Rather, it reflects the broader clinical decision-making, risk assessment, and ongoing management that is unavoidably required with progression from basic airway management to more advanced techniques, such as the insertion of an SGA. For this reason, NEAS' position remains that ASPs may independently undertake the specified basic airway interventions within their authorised scope of practice, whilst the insertion of an i-gel by an ASP should take place under the supervision or direction of a registered healthcare professional, as, for this take place without such supervision, would present an unacceptable level of additional risk to the patient, and unreasonable clinical expectation on ASPs who are not registered healthcare professionals.

Part (iv) - Conclusion

In conclusion, it remains NEAS' position that ASPs should only insert an i-gel under the supervision or direction of a registered healthcare professional, which is based on patient safety, defined scopes of practice, and clinical governance. ASPs are trained and authorised to independently undertake basic airway management techniques and to recognise and respond to complications associated with those interventions. However, the use of an i-gel represents a progression to advanced airway management and introduces additional clinical and device-specific considerations, including appropriate airway strategy, confirmation and ongoing monitoring of effective ventilation, recognition of device displacement or failure, and the ability to modify or escalate the airway management plan where required.

While ASPs may be trained and competent in the technical skill of i-gel insertion, the Trust considers that the broader clinical decision-making, risk assessment, and ongoing management associated with its use should remain under the oversight of a registered healthcare professional. This approach enables ASPs to contribute effectively to the management of critically unwell patients, including initiating immediate life-saving airway and ventilation interventions when first on scene, while ensuring that progression to advanced airway management is supported by the appropriate level of clinical oversight and accountability.

Finally, it should be borne in mind that ASPs are rarely the first responders to C1 incidents, occurring in only an estimated 1.3% of cases, and on average will be backed up by a paramedic-led resource within 3.26 minutes, who are authorised and able to commence advanced airway management techniques, whilst also appropriately monitoring and managing patient risk.

I trust that this response provides you and Edie's family with the re-assurance that NEAS has thoroughly considered your concerns to ensure that patient safety in such critical incidents is preserved and enhanced insofar as possible. If it would be helpful, we would gladly arrange a meeting with our internal Paramedicine team so you can discuss this matter further.

May I once again pass on my sincere condolences to the family of Edie. If we can be of any further assistance then please do not hesitate to [REDACTED] Director of Quality and Safety, via email at [REDACTED]

Yours Sincerely

[REDACTED]

[REDACTED]

Chief Executive