Newcastle and North Tyneside
Miss Georgina Nolan
HM SENIOR CORONER
Civic Centre , Barras Bridge , Newcastle Upon Tyne , NE1 8QH
[redacted]

Date: 9 June 2026
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Director of Paramedicine, North East Ambulance Service

CORONER

1 I am **Miss Georgina Nolan, Senior Coroner for Newcastle and North Tyneside**

CORONER'S LEGAL POWERS

2 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.

INVESTIGATION and INQUEST

On 31 July 2025 I commenced an investigation into the death of Edie Grace Smart. The investigation concluded at the end of the inquest on 5th June 2026. The conclusion of the inquest was Accident. The medical cause of death was:

3 1a Severe hypoxic ischaemic encephalopathy

1b Out of hospital cardiac arrest

1c Drowning

II

CIRCUMSTANCES OF THE DEATH

4 Edie Grace Smart was 13. She died in hospital on the 28th July 2025 having been rescued from the sea at Whitley Bay four days earlier. She had been washed into the sea whilst sitting on some disused steps. The emergency crews tending to Edie struggled to secure her airway. The first ambulance personnel crew on scene were Ambulance Support Practitioners who were not permitted to use an i gel to secure Edie's airway without paramedic supervision.

CORONER'S CONCERNS

5 During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) 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.

(2)

(3)

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you, the North East Ambulance Service have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 4th August 2026. 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.

COPIES and PUBLICATION

I have sent a copy of my report to HHJ Alexia Durran the Chief Coroner, the Local Safeguarding Board and the other Interested Persons below:

- Edie Grace Smart's family

- HM Coastguard

- North Tyneside Council

8 - Tynemouth Volunteer Life Brigade

- Royal National Lifeboat Institution

- Ambulanz Community Partners

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. She 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.

9th June 2026

Signature

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