REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1)** [redacted] Regional Director - NHS England - London
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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** The investigation into the death of Sabrina Stevenson concluded at the end of the inquest on 23 January 2015. The conclusion of the inquest was narrative (Copy attached).
4	**CIRCUMSTANCES OF THE DEATH** Sabrina Stevenson died on 16 December 2012 from a ruptured ectopic pregnancy; she was aged 28. That morning she began to suffer from abdominal pain, diarrhoea and vomiting; she went on to suffer an episode of collapse. Her flat mate called for an ambulance at approximately 6pm. I have set out below my findings of fact based on the evidence heard, including an independent expert opinion from Professor [redacted] The initial triaging of the 999 call prompted a clinical call-back, rather than ambulance attendance; this represented an 'under-triaging' of Sabrina's condition. The call-back did occur within the expected time-frame and retriaged Sabrina as requiring an ambulance to attend within 30 minutes. Demand for ambulances was higher than had been predicted for the time of year. The individual who undertook the call-back assessment did not have access to the current response times for ambulances, which were exceeding the intended 30 minute time-frame. A further call-back occurred after the time-frame for attendance had past; this call was not made by a clinician and did not provide sufficient safety-net advice to Sabrina. There was also no reassessment of the call categorisation, nor (in the alternative) automated recategorisation at this point. One hour after the initial 999 call an ambulance dispatch was attempted; however, this vehicle was part of a pilot scheme which did not accept patients with diarrhoea and

	vomiting. As such, the dispatch request was turned down. I concluded that the pilot scheme was appropriately instituted and the non-attendance was in-line with the clinical guidance. This conclusion was in contradistinction to the ambulance Trust's own internal investigation, which was later recanted by the Trust in evidence at the inquest. Three further ambulances were attempted to be dispatched to Sabrina but were diverted to higher priority calls. An ambulance crew first attended Sabrina approximately two hours after the initial 999 call. The focus of this crew was insufficient regarding the potential for serious abdominal pathology as the cause for an initial low blood pressure and raised heart rate. Hypovolaemic shock was not considered in a meaningful way and too much reliance was placed on Sabrina apparently reporting that she had a contraceptive implant in place. This was contrary to the evidence of her GP, who stated that it had previously been removed. Sabrina presented the crew with a difficult situation regarding her pain management and also the assessment of her capacity to make treatment decisions. There was no formal documented assessment of her capacity. Sabrina suffered a further episode of collapse, which was described by the independent expert as the 'last possible point at which it would be defensible to delay' extraction out of the flat. A second ambulance crew was requested to assist with extraction. There was a failure of appropriate handover to the second crew. They persisted with an inappropriate assessment focus and insufficient consideration as to whether Sabrina had lost capacity to make treatment decisions. The two crews also failed to consider extraction techniques, other than a carry chair. The independent expert set out that there was a failure either to use a system to allow the patient to be carried flat, or to have such a system available. Sabrina subsequently suffered a catastrophic collapse whilst in the carry chair. She went into cardiac arrest and, despite rapid transport to hospital, arriving at 22.41, she was declared dead at 23.24. I heard evidence from a Consultant Gynaecologist, based at the hospital at which Sabrina died. She stated that, had Sabrina arrived in A&E at a point prior to cardiac arrest, then, on the balance of probabilities, the ectopic pregnancy would have been diagnosed and she would rapidly have had life-saving surgery.
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. After concluding the inquest, I received detailed written submissions from LAS, setting out many changes implemented since Sabrina's death. I received written submissions from Sabrina's family in response. I have taken both into account and set out below remaining and additional issues, which it is my duty to raise further. The **MATTERS OF CONCERN** are as follows. – (1) Ambulance response times were the focus of evidence provided at the inquest. The most recent available response times show a worsening picture and submissions to date from LAS set out only a proposed 'investment business case' as to how resources can be freed-up. I have not been provided with the details of this proposal. I am not satisfied that sufficient steps have been taken to demonstrate that the risk of future deaths, from increasing response times, has

	been addressed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that you 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 25 May 2015. 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, Sabrina's family and to other recipients of similar reports arising out of this inquest; namely the The College of Paramedics and LAS. 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	**30 March 2015** **Assistant Coroner R Brittain**