REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. South Western Ambulance Service NHS Foundation Trust ('SWASFT')** **2. [redacted] sister of the Deceased** **3. Care Quality Commission** **4. Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner Area of Avon
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 24th December 2014 I commenced an investigation into the death of Ms. Kala Michelle Skinner, age 44 years. The investigation concluded at the end of the inquest on 6th August 2015. The conclusion of the inquest was that the medical cause of death was I(a) Cardiac failure; I(b) Cardiomyopathy; II Asthma and the conclusion as to the death was Natural Causes. However, at Part 3 of the Record of Inquest I recorded "The deceased was experiencing breathing difficulties and an ambulance was summoned. Owing to incorrect interpretation of clinical symptoms an inappropriate level of response was assigned to the call. This together with a high level of demand and lack of resources on the part of the ambulance service meant there was a significant delay before an ambulance attended. As a result the deceased died before she could be taken to hospital".
4	**CIRCUMSTANCES OF THE DEATH** On 17th December 2014 at 00:00 hours SWASFT received a 999 call via the electronic link from NHS 111 for the deceased who had breathing difficulties. NHS 111 had triaged the call for a response within 30 minutes. There was delay in despatching an ambulance owing to a high level of demand and a welfare call was made at 00:52 hours. At 01:40 hours a Clinical Advisor made contact and following triage retained the same level of response. The Clinical Advisor had 3 years experience in the role and had previously been an Emergency Care Practitioner. At 01:22 hours an ambulance was despatched but recalled within two minutes and diverted to a higher priority emergency call. A further ambulance was despatched at 02:20 hours and again this ambulance was recalled this time within four minutes and diverted to a higher priority emergency call. At 03:03 hours (three hours after the initial 999 call via NHS 111) a further 999 call was received from the deceased's family to advise she had fallen down the stairs and was unresponsive. The call was responded to as an emergency and a Rapid Response Vehicle (RRV) was on scene at 03:15 hours. At 03:17 hours a double crewed ambulance (DCA) arrived on scene. The deceased was found to be in cardiac arrest and died at the scene. According to the level of response initially assigned to the call (Green 2) a welfare call should have been made to the patient / carer every 30 minutes if no ambulance was despatched and attended. Only one welfare call was made, 52 minutes after the initial call, between the initial call at 00:00 hours and 03:03 hours when the second 999 call was made.

	The Clinical Advisor who made contact at 01:40 hours missed critical 'red flags' which meant the priority of response should have been increased from an urgent response (green 2) to an emergency response (red 2). The deceased was known to be asthmatic and was gasping for breath, taking short breaths and was unable to speak in full sentences, all of which were 'red flags' requiring an increased priority of response. Furthermore the deceased was positioned at the top of the stairs and notwithstanding the deceased being in this position and the symptoms the deceased was exhibiting the Clinical Advisor decided that the deceased's daughter, who was with her mother, could go to bed provided she 'kept an ear out' for any deterioration in her mother's condition or the ambulance arriving. In giving such advice the Clinical Advisor did not safeguard against the risk of deterioration nor ensure the safety of the deceased.
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. The **MATTERS OF CONCERN** are as follows. – (1) The Clinical Advisor missed critical 'red flags' thereby failing to recognise the seriousness of the deceased's condition (3) The Clinical Advisor gave inappropriate advice thereby failing to safeguard against the risk deterioration and ensure the safety of the deceased. (4) There was failure to make sufficient and timely welfare calls when a response could not be provided. (5) The Trust should review the training and mentoring of all existing Clinical Advisors with a clear and structured programme to regularly assess and re-assess the competencies of the Clinical Advisors. (6) The Trust should ensure there is proper training, assessment, mentoring and support provided for all newly appointed Clinical Assessors. (7) The Trust is failing to meet it's own target of auditing every month 3% of the calls of Clinical Advisors. In some months no audits at all have been performed. (8) In failing to carry such audits the Trust has identified that there are real concerns that there is no safety net in place to identify potential risks or training needs. (9) The Trust should take immediate steps to ensure the necessary resources are allocated to achieve at least the level of audit the Trust itself has determined necessary. (10) The Trust should have in place a structured response to actioning any deficiencies identified in such audits whether that be for individual Clinical Assessors or as a professional group including trend analysis.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 29th October 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 [redacted] sister of the deceased, and the Care Quality Commission. I shall send a copy of your response to [redacted] and the Care Quality Commission. I have sent a copy of my report to the Chief Coroner. 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	**03 September 2015** **Assistant Coroner**