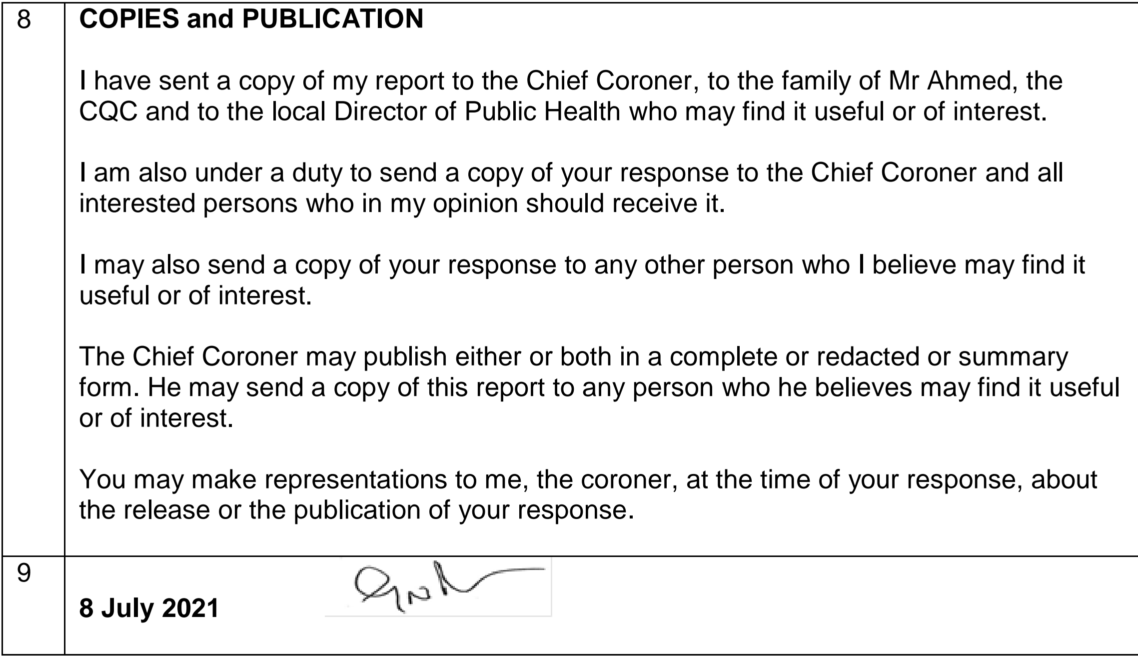
MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Dr , Medical Director, London Ambulance Service NHS Trust, 220 Waterloo Road, London, SE1 8SD **2.** Dr , Medical Director, London's Air Ambulance, 5th Floor, 77 Mansell Street, London, E1 8AN
1	**CORONER** I am Nadia Persaud, H.M coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 21st February 2020, I commenced an investigation into the death of Nadeem Ahmed. The investigation concluded at the end of the inquest on 16th June 2021, The conclusion of the inquest was a narrative conclusion: *Mr Ahmed died as a result of the traumatic exsanguination of his brachial artery. His death was contributed to by a failure to provide accurate and relevant clinical information to the HEMS team and by a failure to ensure the earliest possible activation of the*

	HEMS clinicians, through correct emergency call triaging. These failures denied Mr Ahmed the opportunity of receiving life saving treatment prior to his cardiac arrest.
4	**CIRCUMSTANCES OF THE DEATH** Mr Ahmed lacerated his brachial artery when he put his hand through a glass pane in a door at his home address, on the 8 February 2020. Two calls were made to the London Ambulance Service and both calls were incorrectly triaged. The correct triage would have resulted in an earlier attendance of the first LAS unit, by around two minutes. On arrival of the emergency ambulance crew, Mr Ahmed had clear signs of hypovolaemic shock. There was a failure by a crew member to provide accurate and relevant clinical information to the HEMS team. Had relevant and accurate clinical information been provided, the HEMS team would have attended. They would have administered sedation; inserted a central line and administered blood products. Such clinical interventions, would on the balance of probabilities have prevented Mr Ahmed's death. The correct triaging of the 999 calls, would have provided an opportunity for the earlier attendance of the HEMS team. This would have increased the likelihood of successful lifesaving treatment. Mr Ahmed did not receive any bloods prior to his cardiac arrest. He arrested on route to the Royal London Hospital. Sadly, Mr Ahmed suffered multiple organ ischaemia and he passed away at the Royal London Hospital on the 13 February 2020
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 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: At the time of communication between the LAS paramedic on scene and the paramedic on the HEMS dispatch desk, Mr Ahmed was in a state of hypovolemic shock. He had a very high pulse rate, a very high respiratory rate, had suffered a brief loss of consciousness and had a concerning pallor. This clinical picture was not conveyed to the HEMS desk. The paramedic on scene did not offer accurate and relevant clinical information. The paramedic on the HEMS desk requested only the GCS and not the full clinical parameters. There may be an opportunity to improve communication between the HEMS dispatcher and paramedics on scene, by joint training and/or provision of a check-list for key clinical parameters to be shared. A senior HEMS clinician gave evidence at the inquest. He stated that video link communication might also aid in the transfer of relevant and accurate clinical information.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **1 September 2021**. 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, to the family of Mr Ahmed, the CQC and to the local Director of Public Health 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 other 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.
9	**8 July 2021**