**IN THE SURREY CORONER'S COURT**

**IN THE MATTER OF: Josephine Celia BARKER**

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**The Inquest Touching the Death of Josephine Celia BARKER**

**A Regulation 28 Report – Action to Prevent Future Deaths**

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| | • **SECAMBS and NHS England** |
| 1 | **CORONER**<br><br>J. Russell-Mitra HM Assistant Coroner, for the County of Surrey |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>An inquest into the death of Josephine Celia Barker was opened on 26th March 2019, concluded on 13th November 2021.<br><br>I found that the cause of death was:<br><br>1a Intracranial haemorrhage.<br><br>I concluded with a narrative conclusion as follows: |

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| | On 15th February 2019 Ms. Josephine Celia Barker at about 13.00 had an unwitnessed fall in Aldi car park, Kingston Road, Ewell, and suffered a serious head injury. She was attended to my members of the public who made five 999 calls over the course of two hours. The incident was given a Category 3 disposition requiring emergency response within 2 hours by SECAMBS. At 15.33 one of the members of the public assisting her flagged down a passing London Ambulance Service vehicle. Whilst loading her onto the ambulance, an ambulance from SECAMBS arrived. Ms Barker was taken to St George's hospital, Tooting, where she underwent craniotomy. She succumbed to her injuries on 3rd March 2019 at 12.25<br><br>Accident contributed to by neglect<br><br>I adjourned consideration of whether to write a report for the prevention of future deaths for further evidence to be provided by the 24th March 2021. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>i.) On 15th February 2019 Ms Josephine Celia Barker (hereinafter "Jo" at the behest of the family) fell in the car park of Aldi in Ewell in Epsom at around 1300. It has not been possible to identify and bring to court anyone who witnessed the fall itself. Jo was as far as can be ascertained shopping alone, and there is some suggestion she was carrying something across the car park, perhaps an exercise ball and that she fell backwards. There is no direct evidence of how that fall occurred. [redacted] evidence is that having arrived on the scene when called due to the fall, she spoke to Jo whislt on the floor and Jo could not say if she had fallen or tripped.<br>ii.) The scene in the aftermath of the fall was confused and confusing with various by-standers involved at different times.<br><br>iii.) It is possible that Jo had been hit by a reversing car but that the gentleman driving did not think he had hit her and had been reversing very slowly. An ambulance was called but the police were not asked for and no investigation took place. None of the people present at the time knew Jo. The fall seemed to happen very fast in a busy car park when the by-standers were not expecting it and therefore no one appears to have been watching. [redacted] told me that a lady had seen it and had said Jo had been standing and then fell backwards without bracing her fall. She was reported to have been shaking with a potential seizure straight after the fall.<br><br>iv.) Having collapsed, fallen, tripped or been hit by the car, Jo landed on the floor and did not get up. She was rolled into the recovery position by one or more by-standers. A number of people had placed coats on her as it was a |

cold February day and she was lying on the asphalt of the car park.

v.) She was attended by an off-duty paramedic. Jo was drowsy and able to respond to short questions, although he was not sure whether she understood the questions. She mostly answered "feel sick". She denied pain in her head and neck. She was nauseous and had vomiting episodes. The off-duty paramedic described trying to sit her up and that she would wake up slightly, lean herself up on her elbow, but want to lie down again immediately. Her head was felt for injury and initially there was not any to be felt but a bump developed. Throughout she was able to respond to voice by opening her eyes.

The store manager came out and at some point a chair was provided as [redacted] told me he was concerned about Jo becoming too cold. Jo was able to weight bear to the chair and later to the ambulance trolley. She remained at all times confused, nauseous and drowsy.

11. There were 5 calls to 999 about Jo.

12. The first call: 13.04 lasted 12 mins 27 seconds. This call has been audited and there are concerns about it. In spite of the caller's willingness to answer all questions asked of her as well as she could in a busy car park about a stranger the call is exited without triage ("early exit").

13. The second call- 13.04 and lasted for 4 mins and 36 seconds. This is by another bystander who is further away than the first caller. This caller initially thought it was a male who had been hit by a car but corrected it as the call went on. Again, the call handler was told that there was an off-duty paramedic on scene and did not ask to speak to him. This call was terminated by the call handler on realisation that this was a duplicate call to the initial call that was still ongoing. No triage was done during this call although it would have been possible to do so.

14. During these two calls, as soon as "unconscious" was said this immediately leads to a Category 1 disposition. As the calls went on this was downgraded to Category 2 and then by about the middle of the first call, it had become a Category 3 disposition based on early exit of the call as the call handler did not consider triage possible.

15. The first ambulance – call sign 219- was allocated at 13.04:50 from Epsom ambulance station. At this point, Jo's call was a still a category 2 (18 minute response). As the call with the first caller was still ongoing and it was downgraded to category 3 (2 hr response) at 13.06:53, call sign 219

was diverted to another category 2 call. Although at this stage the ambulance was very close to Jo, it was not within the 500m of the incident and therefore according to policy could be diverted to a more urgent call.

16. The second ambulance- call sign 607- was allocated at 13.07:45. The crew had not had their meal break and according to policy they must have it by the fourth hour of their shift. It was unclear whether re-allocation to meal break can take place after dispatch.

17. The third 999 call was at 13.26:06). This is what is termed an ETA call, that is a call which is made by someone on scene to ascertain how long the ambulance will be. The call was dropped or lost. The policy is that any dropped call will trigger three call backs in an attempt to speak to the person calling. No call backs were made at all. There is no proffered reason why.

18. The fourth call was at 14.14 for 7 minutes and 28 seconds. It was assumed that this was the first caller but was in fact a different new caller altogether ("caller 4"). This is relevant because during an ETA call, which this is classified as, the call handler (who is the same throughout save for on call 2 which was happening at the same time as call 1) asks the "worsening condition" question. This question should be asked on all follow-up calls and is phrased in various ways but is asked in case re-triage is necessary. It is asked to find out if there has been any change in the initial circumstances. Jo has at this time been lying on the ground of a supermarket car park on a cold February day during a busy Friday lunchtime for at least an hour and fourteen minutes. When the call handler asks: "Has anything got worse for Jo?" she is asking a question against a baseline that caller 4 does not know. Caller 4 told the handler that the lady who called the ambulance had gone and they (the people on scene) are doubting whether she called it because of the length of time. This indicates to the call handler that Caller 4 was not Caller 1 and was not part of the initial phone call. She therefore would not know what had been told to the handler about Jo's condition in the first instance. The call handler did not tell Caller 4 what she knew about Jo's accident or her injuries or condition. Caller 4 described that Jo kept being sick and that "every time she gets her head up she is sick". When the call handler asks if the vomiting had got worse Caller 4 replies "it's sort of the same". Jo has at this point been vomiting for over an hour following the fall. Caller 4 further described Jo as coming in and out of consciousness: rousable if shaken but only to say "sick, sick" and able to move only to be sick. No re-triage is done in spite of Caller 4's willingness to answer questions. No attempt is made to speak to the off-duty paramedic who is still on scene.

19. The next 999 call was at 14.40 from an off-duty HART paramedic who had arrived on the scene as a passer-by. He gave detailed information to the call handler whilst asking for an ETA and he passed the phone to the off-duty paramedic who had been with her from the beginning. The off-duty paramedic who had been with her for some time made a request for a category 2 due to Jo's condition. The call handler checked with him if there was any immediate threat to her ABCs (airway, breathing, consciousness) and when told no refused the category 2. There is a policy that if a call handler is asked by a health professional with a patient for a particular category of call that should be heeded and the health professional requesting it would then bear the responsibility of the decision-making. This was not followed.

20. At 14.56 all sign -239 was allocated from Redhill Ambulance station after the end of their meal break. After the allocation had been made and the wheels were in motion, the dispatcher had made a call to the crew asking them if they would like to attend a welfare meeting with their manager. Welfare meetings are an essential way of taking care of crew. They provide a debrief session after a crew has attended an incident that may have affected them (e.g. a death etc). I have listened to the call made to the crew. The crew are given the opportunity to be stood down and return to their station or to continue on to Jo. The crew chose to continue to Jo. However, the dispatcher tells them to wait where they are as their manager is in another meeting but will be with them shortly. The crew do as asked and return to the station. There is no policy about when to stand down an ambulance in these circumstances. There are times after allocation when an ambulance can be stood down but this situation is not covered. The crew were already on the way, albeit they had not gone very far, and were turned back. This appeared to be a dispatcher decision and made without reference to Jo's situation although the dispatcher would have been aware that in 10 mins they would be in breach of the 2 hour maximum time-limit. There is no explanation why this particular decision was made only that there is a policy about welfare meetings in place.

21. At 15.04 it was 2 hours from the first call to the ambulance. SECAMBS policy requires a callback to anyone in Cat 3 who has been waiting over two hours because the maximum time limit for arrival of the ambulance has been breached. There was no callback at any time nor any reason for the call handler not doing so.

22. At 15.12:25 call sign 281 was allocated to Jo and was at that time in Merstham having been stood down from a now downgraded category 2 and therefore able to sent to Jo's category 3 which was one of the older calls still in the system. This ambulance arrived at the Aldi car park at

15.34:29.

23. At around 15.30 one of the off-duty paramedics flagged down a passing ambulance. This was a London ambulance call sign R107 and two paramedics were aboard. Their ambulance was on its way to a cat 2 incident but stopped to render aid and assistance. One of the ambulance paramedics stated that he was told Jo was in need of urgent assistance and that she had by this time been waiting over two hours for an ambulance. He made a call to his Emergency Operation Centre and the original cat 2 call his vehicle was on was re-allocated and his vehicle was tasked with Jo.

24. He was told she had collapsed and took a handover from the off-duty paramedic who had been on scene almost throughout The ambulance paramedic (from R107) described JO as being hunched over with her head in her hands and not well- she looked grey, haggard, barely moving and was able to grunt. She looked, he said, time-critical. She was unable to reply verbally only to grunt. He described what he could see and what he had been told to his Control and they gave him a category and formally assigned the job to them.

25. Jo was rousable to pain but not to voice and with a Glasgow Coma score (GCS) of 12 at this stage. There was a small contusion to the back of her head. R107 paramedics expressed concern that even for someone fit and well there would have been a risk of hypothermia given the conditions on that day. There was concern that she had suffered a tonic-clonic seizure either after the fall as she had been described to have fitted. There was concern about the potential of stoke, traumatic bleed on the brain or other neuroevent. Her temperature was 34.7, pulse irregular and her left pupil was not reactive.

26. R107 paramedics categorised the incident as a category 2 and stated that it triggered the London Ambulance Service major trauma protocol.

27. Some people assisted Jo to the trolley. As R107 paramedics were assisting Jo into the ambulance, the SECAMBS vehicle arrived – that is call sign 281 which had been dispatched from Merstham at 15.12:25 and the paramedics with that vehicle assisted.

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| | 28. At 15.54 call sign R107 left the car park, Jo was placed onto high flow oxygen, the blue lights were turned on and the hospital alerted to her condition. During the journey to the hospital she was reassessed and her pupils were dilated and blown, she was agitated with irregular pulse and involuntary movement of the arms. By the time the ambulance reached SGH at 16.13 Jo's GCS was 5.<br><br>29. A CT scan of Jo's head showed a large right-sided acute subdural haematoma associated with a cerebral haematoma affecting the right thalamus which had ruptured outwards. At 17.30 she was taken to theatre and a craniotomy was performed which was successful in relieving the pressure on the brain. However, Jo's right pupil was unresponsive at the end of the operation.<br><br>30. Jo was transferred to Neurological ICU where she was unstable and with raised troponin levels. Sedation was lightened and she showed extension and flexion responses. Her right pupil reduced in size and became reactive. She was treated with I/V antibiotic care for presumed sepsis. She became more stable in her vital signs but showed no meaningful neurological improvement over the next few days and Treating doctors discussed her situation with her family and she was placed into palliative care on 23rd February 2019 and succumbed to the injury on 3rd March 2019. Her time of death was 12.25.<br>31. There had been intraparenchymal haemorrhage from rupture of the brain vasculature and subdual haemorrhage as direct trauma. |
| 5 | CORONER'S CONCERNS<br><br>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.<br><br>The MATTERS OF CONCERN are as follows. –<br><br>1. The initial early exit of the first 999 call without full triage- this results in a category 3 response. There is no reason full triage could not have continued.<br><br>2. London Ambulance have a different major trauma protocol to SECAMBS and the fact that Jo had been potentially hit by a car – even moving slowly- and had a head injury would have been enough for the |

Major Trauma protocol for London Ambulance. SECAMBS major trauma protocol was not triggered because even if she had been hit by a car it was not moving fast enough to justify a major trauma category (cat 2).

3. An off-duty paramedic was on scene throughout and had clinical experience which was not asked for until the final 999 call when the call handler was passed to him by the second off-duty paramedic (from HART) who had arrived on scene and made the call. There has been no reason given as to why the off-duty paramedic's assessment was not asked for earlier and I was told that there is a policy in place with reference to Health Care Professionals which has since been updated but does

4. There was no Clinical Safety Navigator in place to manage the Welfare Stack. This is an alert that gives an indication to those viewing the list of cases waiting for an ambulance of the priority of the call within its category. Jo's case had a number of features which would have led to it becoming a priority within its category and potentially being upgraded: the incident was outside and therefore less safe and comfortable than waiting in a home/workplace; the day was very cold and there was a risk of hypothermia particularly as Jo was lightly dressed in gym clothes and lying on the asphalt of the car park floor and as time passed she had been waiting a long time and finally her case breached its time limit.

5. At no point did a clinician have any input into the calls after the initial question from the call handler of call 1 as to whether this was major trauma or not and therefore there was no clinical assessment by SECAMBS of Jo's condition over the following two and a half hours: she was vomiting for over two hours after the fall, she had fluctuating consciousness and was rousable to shaking and not to voice. She had had a tonic-clonic seizure and had potentially been injured by being hit by a car. She was unable to open her eyes.

6. There should have been a clinical review at 2 hours. I have heard that there was not because there were not enough clinicians available.

7. There were no callbacks made either to the caller whose call was dropped or to any of the callers at the 2 hour mark.

8. There is a concern over the NHS Pathways tool's ability to deal with fluctuating consciousness. This is because there is only an assessment on conscious or on unconscious so moving between the two states triggers the call handler to move into the conscious or unconscious pathway respectively but is not able to take into account fully that conscious level is impaired or mixed. This is considered as a huge challenge to any call handler even a clinician as it then is not established if the patient is conscious or unconscious and it forces the call handler to restart triage with each change. I was told that this can

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| | cause issues as it means it then leads to lots more questions when the person on the scene is already in a difficult situation.<br><br>9. When Jo was reported as drowsy, this was not considered as a new symptom and she was not re-triaged.<br><br>10. When speaking to different members of the public the questions about worsening condition were not contextualised so the caller is unable to be sure what information the call handler already has.<br><br>11. Jo's vomiting was not the same symptom over time. Vomiting initially after a head injury is not the same as still vomiting after it two hours later.<br><br>12. The off-duty paramedic request re categorisartion was not followed and the challenge to it did not lead to a clinical discussion.<br><br>13. The continuous CAD was not kept updated with details of Jo's condition or other useful information when each of the calls came in.<br><br>14. Call sign 239 was diverted to a welfare briefing after it had been allocated. There is no policy guiding making this decision **after** allocation has been made and the ambulance is en route. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report. I, the coroner, may extend the period.<br><br>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** |

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| | I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;<br><br>[redacted].<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Signed:**<br><br>**J. Russell-Mitra**<br><br>**Dated this 7th March 2022** |