INQUEST TOUCHING ON THE DEATH OF MIA GIBSON

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Richard Henderson, Chief Executive, East Midlands Ambulance Service NHS Trust ('EMAS')** **2. [redacted] Chair of Association of Ambulance Chief Executives ('AACE')** **3. [redacted] Complaints and whistleblowing manager, Sustainable Improvement Team, NHS England** **4. [redacted] Accountable Officer, NHS Hardwick Clinical Commissioning Group ('CCG')**
1	**CORONER** I am Heidi Connor, assistant coroner for the coroner area of Nottinghamshire.
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 7th December 2015 I commenced an investigation into the death of Mia Gibson (age 7 hours). The investigation concluded at the end of the inquest on 5th May 2016. The conclusion of the inquest was a narrative conclusion as follows : Mia Gibson died on the day of her birth, 16 November 2015, at Queen's Medical Centre, Derby Road, Nottingham. Her mother had an uncomplicated and low risk pregnancy, but suffered a sudden and unexpected placental abruption on 16 November 2015. There was no available ambulance to take her mother to hospital initially, resulting in delay in her delivery. The evidence suggested that delivery anything up to 20 minutes earlier is likely to have avoided Mia's death. The medical cause of death was : 1a Severe hypoxic ischaemic encephalopathy 1b Placental abruption.
4	**CIRCUMSTANCES OF THE DEATH** Mia Gibson's mother is [redacted] Her father is [redacted] had an uneventful and low risk pregnancy. She and her partner had attended all antenatal appointments together. [redacted] suffered a placental abruption in the early hours of 16 November 2015. [redacted] rang the maternity unit and reported that [redacted] had lost a significant amount of fresh red blood. They were advised that [redacted] should come in to hospital. They were advised to ring an ambulance for that purpose. They did not have their own transport, but the midwife also felt that would be the fastest and safest way for [redacted] to come in.

	A call was made by [redacted] to East Midlands Ambulance Service at 0229 hrs. It was categorised as Red 2. No double-crewed ambulance ('DCA') was available to attend – the nearest resource was a fast response vehicle ('FRV'), then in Ripley in Derbyshire. It was accepted in evidence that [redacted] was highly likely from the outset to require transfer to hospital – indeed that was the purpose of the 999 call. The FRV paramedic attended, arriving at 0245 hrs. He was told that [redacted] had lost "2 or 3 coffee cups" of fresh red blood, and he called for Red back up at 0248 hrs. Again no DCA was available. The evidence was that, of the 10 ambulances operating within a 30 minute radius of the scene, 8 were unavailable as they were attending scenes (eg handing over patients at hospital). The remaining 2 were marked 'NPR' (or no planned rest) – ie they had gone beyond their meal window periods, and were therefore both on compulsory breaks – which can only be disturbed for a cardiac arrest call. I made clear at the inquest that I am in no way critical of systems requiring crews to take breaks, which I accept are vital for staff wellbeing, safety, and staff retention. The evidence also suggested that many problems regarding availability of crews stem from delayed handovers of patients to hospital staff. A crew became available at 0300 hrs, and was immediately dispatched to the scene, arriving there at 0312 hrs. They left the scene at 0321 hrs, arrived at hospital at 0332 hrs and handed over to maternity staff at 0344 hrs. [redacted] was reviewed immediately by midwives and doctors and Mia was delivered extremely quickly, at 0404 hrs. She was in a very poor condition from birth, and despite the involvement of neonatal doctors from the time of her birth, she died, with her parents, that day. Evidence suggested that delivery anything up to 20 minutes earlier would, on the balance of probabilities, have avoided Mia's death.
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. It appears that great reliance was placed on the fact that [redacted] was not in pain and had normal observations. Little consideration appears to have been given to the 'second patient' (Mia), whose condition could not be monitored by paramedics. We heard evidence that in fact not all placental abruptions cause the mother significant pain, or concerning observations, but for the baby, it can be akin to a cardiac arrest. This factor appears to have been overlooked in the trust's subsequent investigation report, which refers several times to how reassuring [redacted] clinical condition was, and was repeated in evidence by the paramedic witnesses. This is a clear training issue, and may well apply nationally. 2. No 'open mic' report was put out to see if other crews could make themselves available to attend this emergency. 3. Dispatchers appear to have allowed a situation to arise whereby the only 2 DCAs not attending other jobs were both on compulsory meal breaks and therefore unavailable at the same time. Whilst meal breaks are vital for staff, planning the timing of these, by ambulance control, is critical for patient safety. Meal break management is already under review by EMAS. 4. It was suggested that obstetric emergencies such as placental abruption could

	5. It is clear that resources played a part in these tragic events. No DCA was available to attend this emergency until 30 minutes after the call, and it took a further 12 minutes for a DCA to arrive after that. The time between the 999 call and [redacted] being handed over to maternity staff was an hour and 15 minutes. It was clear from the outset that [redacted] would require urgent transfer to hospital – a mere 4 miles from her home address – but no resource was available. The evidence of those 'on the ground' clearly showed that this is far from an isolated incident, and I remain concerned that there is a risk of future deaths if this is not addressed.
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. For the avoidance of doubt, I require responses as follows : 1. From EMAS on matters of concern listed above at paragraphs 1, 2, 3 & 4. 2. From AACE on paragraphs 1 and 4. 3. From NHS England and the CCG on paragraphs 4 (insofar as this relates to matters of resource) and 5.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 July 2016. 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 and to Mia's parents. I have also sent a copy to Wendy Hazard at EMAS. 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	**11 May 2016** **HJ Connor**