Wyllow-Raine Lawson Swinburn

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: [redacted], CHIEF EXECUTIVE of SOUTH CENTRAL AMBULANCE SERVICE**
1	**CORONER** I am Mr Darren Salter, Senior coroner, for the coroner area of Oxfordshire
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 2nd December 2024 at Oxfordshire Coroner's Court I conducted the inquest into the sad death of Wyllow-Raine Swinburn, aged 3 days, at the John Radcliffe Hospital Oxford on 30th September 2022. Her cause of death was found to be congenital hyperinsulinism and hypoglycaemia leading to a cardiac arrest. I returned a Narrative Conclusion as follows; *Wyllow-Raine Swinburn was born on 27th September 2022 at the John Radcliffe Hospital, Oxford. She was discharged on the evening of 29th September 2022 with no significant concerns and went home with her mother to [redacted], Didcot. She fed that evening and in the early hours. She stirred again at approximately 04:00 hours and her mother attempted to feed her but at approximately 04:36 hours her movements suddenly stopped, and she became unresponsive. An ambulance was called at 04:38 hours, but the call did not connect to an ambulance service until 04:45 hours when instruction on CPR was given and followed. The first paramedic arrived at approximately 05:09 hours and took over CPR, assisted by other ambulance personnel, who arrived a few minutes later.* There was helpful evidence in the form of statements from SCAS staff including [redacted], who also gave oral evidence. South Central Ambulance Service (SCAS) were legally represented and provided with a copy of the inquest file.
4	**CIRCUMSTANCES OF THE DEATH** The brief circumstances of Wyllow-Raine's sad death are set out in the Narrative Conclusion above. It will be seen there was a delay of 7 minutes in the 999 call being connected to an ambulance service, initially East Midlands and then SCAS. The response time for the first paramedic to attend was 31 minutes. She died in hospital on 30th September 2022.

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 two concerns relate to, firstly, the length of time for the 999 call to be connected to a ECT (Emergency Call Taker and, secondly, the length of time for an ambulance/paramedic to attend. I fully appreciate there have been very significant demands on ambulance services including on SCAS in the past few years. I also understand, from the written and oral evidence of [redacted], that multiple actions have been undertaken to improve ECT staffing and inconsistency. My primary concern is in relation to this first issue. I realise there will be occasions when ambulance resources, particularly in the early hours when there are fewer resources, happen to be located in a different area leading to prolonged response times. It would seem that the issue of the delay in being connected to an ECT is more amenable to a systems improvement, particularly when one considers that arrangements are in place for calls to default to other ambulance services who may be less busy or who have greater capacity. Given the risk associated with delayed response times, particularly in connecting to an ECT, I request that the concerns I have raised are considered and that you respond thereafter. I would be interested to learn if actions identified as part of SCAS's own internal review have been fully implemented and are subject to auditing to ensure compliance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you South Central Ambulance Service 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 1st April 2025. 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 [redacted]-SCAS Legal Service Manager The Family of Wyllow-Raine Swinburn 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	**[DATE]** **3rd February 2024**	**[SIGNED BY CORONER]**