REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)]
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 the 27th of March 2013 I commenced an investigation into the death of Frederick Douglas Pring (DOB 2.08.1938, DOD 21.03.2013). The investigation concluded at the end of the inquest on the 20th of January 2014 and I recorded an narrative conclusion in respect of the death in the following terms :- On the evening of the 20th of March 2013, Fred Pring began to experience chest pains and at 01.08 the following morning, his wife telephoned 999 and requested help for her husband by way of the attendance of an ambulance at their home address of [redacted] Due to a combination of delays in handing over patients at hospitals and ambulance crews being on rest breaks, there were no resources available to allocate to this call nor to the further two calls made by [redacted] at 01.19 and 01.38. Following a fourth and final call at 01.51 in which [redacted] informed the call handler that her husband had died a few minutes earlier, three ambulances reached the property, the first of these arriving some 48 minutes after the initial call. The crew of this ambulance implemented their Recognition of Life Extinct policy verifying his death at his home address on the 21st of March 2013. A post mortem later established that Fred Pring had died from a combination of the natural disease processes of Ischaemic Heart Disease and Severe Chronic Obstructive Pulmonary Disease. Although it cannot be established with certainty that Mr Pring would have survived if help had reached him sooner, it is probable that if an ambulance had arrived promptly after the first call, (that is to say within their target response time of eight minutes), he would have lived long enough to be transported to hospital where further medical treatment would have optimized the prospects of his survival.

4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are as set out in the narrative conclusion appearing in paragraph 3 hereof.
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 :- That the current practices in place for the handover of patients at an Emergency Department far too often results in wholly unacceptable delays with patients being kept waiting for long periods in ambulances and ambulance resources consequently being unavailable for allocation to other calls. Whilst this is a multi-factorial problem, improvements must be made so as to reduce the risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 18th March 2014 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 the following Interested Person – [redacted] (wife of the Deceased) 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	**[DATE] 21st January 2014** **[SIGNED BY CORONER]**