Nicola Jones
Assistant Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **CHIEF EXECUTIVE WELSH AMBULANCE NHS TRUST** **FIRST MINISTER MR CARWYN JONES, WELSH ASSEMBLY GOVERNMENT** **HEALTH MINISTER MR MARK DRAKEFORD, WELSH ASSEMBLY GOVERNMENT** **CHAIRMAN AND CHIEF EXECUTIVE EMERGENCY AMBULANCE SERVICE COMMITTEE FOR WALES**
1	**CORONER** I am Nicola Jones, Assistant Coroner for North West Wales
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 21/08/2014 I commenced an investigation into the death of Jasmine Ruby Lapsley. The investigation concluded at the end of the inquest on 12 January 2016. The conclusion of the inquest was that Jasmine's death was due to an accident. The medical cause of death was 1a. Choking.
4	**CIRCUMSTANCES OF THE DEATH** On 19 August 2014 6 year old Jasmine Lapsley was on holiday with her family at a property in Morfa Nefyn on the Lleyn Peninsula in the County of Gwynedd. At 20.30 hours Jasmine choked on a grape. Her father [redacted] tried to dislodge the obstruction immediately by backslaps and the Heimlich Manoeuvre. Jasmine stopped breathing and was unresponsive. At 20.31 hours Jasmine's grandmother ran 999 and spoke to Ambulance Control at 20.32. The call was registered at 20.34 hours. The call was correctly classified as RED 1, the most serious requiring attendance without delay. The response time for Welsh Ambulance NHS Trust arriving at RED 1 patients is to arrive at 65% of patients within 8 minutes. The nearest two ambulances at Pwllheli, some 7 miles away were not available. The next nearest available ambulance was dispatched at 20.33. This was at Porthmadog , 20 miles and some 24 minutes from Morfa Nefyn. The roads between Morfa Nefyn and Porthmadog are winding, narrow and down to one lane in many places. Ambulance Control contacted Community First Responders in Morfa Nefyn but all calls went to voicemail. At 20.35 two Community First Responders contacted Ambulance Control to confirm that they could attend and were mobilising. They were some 7.5 miles and 19 minutes away. Community First Responders are unpaid volunteers trained by Welsh Ambulance NHS Trust (WAST). They are trained in basic first aid and are equipped with defibrillators and other essential equipment to maintain an airway and perform CPR and keep a patient alive until an ambulance or other WAST resource arrives. Community First Responders are a valuable resource in rural and remote areas. Under current arrangements when they are available they inform Ambulance Control. There is no formal rota system ensuring continuous cover in all areas. The method for contacting CFRs is generally by mobile telephone which is not a reliable form of communication in rural and remote areas due to the patchy

37 Castle Square, Caernarfon, Gwynedd, LL55 2NN
Tel 01286 672804 | Fax 01286 675217

availability of networks.

During the Inquest the Manager of Ambulance Control gave evidence that had the 999 call been received at 6 pm then the Air Ambulance would have been dispatched immediately given the gravity of the situation. Wales Air Ambulance is a charity which exists solely as a resource for WAST. It is classed as a WAST resource. It is clear that the incident involving Jasmine required the immediate dispatch of Air Support. Wales Air Ambulance only flies between 7 am and 7 pm. There was no WAST resource Air Support available for Jasmine.

It is the practice of Ambulance Control to go through all WAST resources to ascertain whether they can assist before contacting alternative support. This was the reason given by WAST for not contacting the RAF 22 Squadron Search and Rescue helicopter until 20.46, 13 minutes after the original 999 call. They were already airborne and proceeded straight to Morfa Nefyn.

Whilst the 999 call was in progress a neighbouring off duty police man attended and commenced CPR, shortly followed by his wife, an employee of WAST and a first aid trainer. They relentlessly carried out appropriate CPR in an attempt to resuscitate Jasmine. Some air was entering her lungs as evidenced by the rise and fall of her chest. It is likely by this stage that the grape was no longer fully occluding the airway and was dislodged to some extent by back slaps. At 20.45 a local fire crew were flagged down by a family member and assisted briefly in CPR before the neighbours took over once more. This CPR continued until the ambulance arrived.

The Community First Responders attended at 20.54 hours. The ambulance was logged by Ambulance Control as being 200 metres away at 20.57. The RAF aircraft arrived within minutes of the ambulance. Jasmine was transferred from the ambulance to the aircraft and airlifted to Ysbyty Gwynedd, Bangor. She arrived in the Emergency Department at 21.33. Despite of the best efforts of the clinicians at the Emergency Department to resuscitate Jasmine the decision was made to withdraw treatment and Jasmine sadly died at 23.58 hours.

RAF 22 squadron Search and Rescue helicopter were often called to assist WAST when WAST were unable to attend to retrieve and/or treat patients. Unless involved already in their primary duty of Search and Rescue the RAF always assisted WAST. The duties of RAF Search and Rescue in North West Wales were transferred to a private company Bristows in 2015. Bristows continue to assist WAST as the RAF did previously. WAST had no Protocol, Memorandum of Understanding or Standard Operating Procedure to formalise or govern the relationship between WAST and RAF. The position remains the same with Bristows. This is not a reliable resource for WAST as is only available when not engaged on their primary duty of search and rescue. There is no obligation upon them to assist in any event.

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) There is no reliable WAST Air Support in North West Wales during the hours of 20.00 hours and 07.00 hours, those being the hours not covered by Wales Air Ambulance or the recently introduced Emergency Medical Retrieval Teams. WAST should review this gap in air support which an essential asset in accessing, treating and retrieving critically ill or injured patients, particularly in remote and/or rural areas. (2) There is no effective rota system for Community First Responders to ensure consistent cover by these local volunteers who provide essential support for patients in remote and/or rural locations in North West Wales. The method of communicating Community First Responders to ask them to attend an incident is by mobile telephone although this is fraught with difficulties in remote and/or rural areas where network coverage can be patchy at best and frequently non existent. WAST should review the systems in place for rostering and contacting Community First Responders to ensure more consistent cover and more reliable communication. (3) Given the difficulties in ambulances arriving at many rural and/or remote areas in North West Wales it is essential that there are sufficient local Community First Responders to arrive promptly at the casualty and provide essential treatment preserving life until an ambulance arrives. WAST should review the planning for the recruitment and retention of Community First Responders. (4) The population of many rural and remote areas of North West Wale increases significantly during the months of July and August. WAST currently do not provide increased resources during these two months to cope with this increase in population. WAST should review their planning for effective allocation of resources to ensure the safety of this population during the months of July and August.

37 Castle Square, Caernarfon, Gwynedd, LL55 2NN
Tel 01286 672804 | Fax 01286 675217

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 11 March 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 the following Interested Persons , Chief Executive Betsi Cadwaladr University Health Board, Solicitors for [redacted] Lt Col [redacted] Ministry of Defence[and to the LOCAL SAFEGUARDING BOARD. I have also sent a copy to the Chief Executive of Abertawe and Bro Morganwg Health Board as host for EMERTS and Chief Executive for Wales Air Ambulance. 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	Dated 15 January 2016 Signature N Jones Assistant Coroner for North West Wales

37 Castle Square, Caernarfon, Gwynedd, LL55 2NN
Tel 01286 672804 | Fax 01286 675217