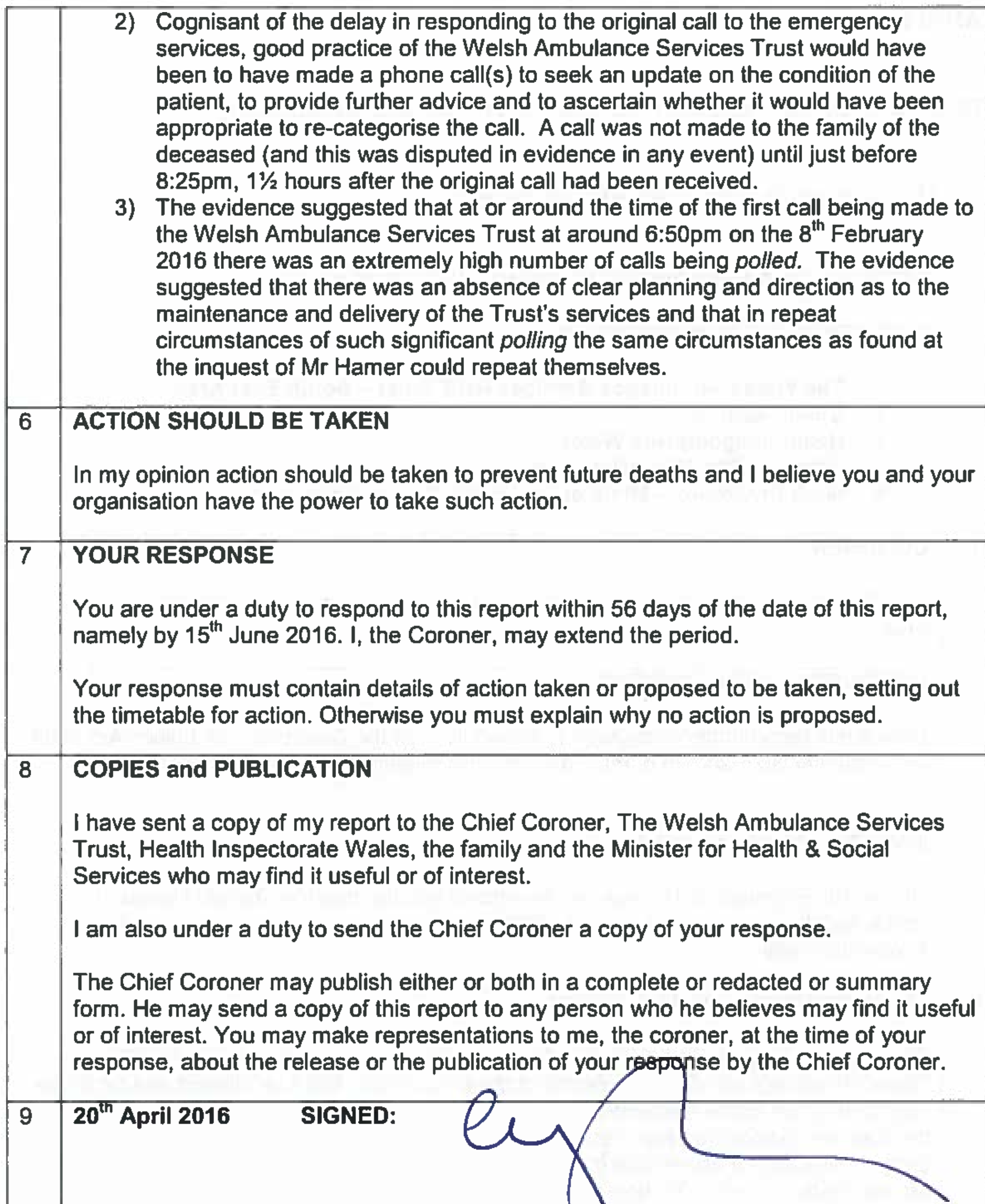
ANNEX A

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:** 1. **The Welsh Ambulance Services NHS Trust – South East Area** 2. **Chief Coroner** 3. **Health Inspectorate Wales** 4. **Family – [redacted] (Daughter)** 5. **[redacted] – Minister for Health & Social Services**
1	**CORONER** I am Graeme Hughes, Assistant Coroner, for the coroner area of South Wales Central Area.
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 16th February 2016 I opened an inquest into the death of Ronald Hamer. I concluded that inquest on the 13th April 2016. The conclusion of the inquest was Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was an independent elderly gentlemen living at his home at [redacted], [redacted]. On the morning of the 8th February 2016 he slipped and fell in the bathroom of his home sustaining an injury to his right arm. He became immobilised on the floor remaining in an awkward position whereby his right arm was trapped by his body. This incident occurred around 5am and he was not discovered by his family until around 6:45pm - over 13½ hours later. A call to the emergency services was made at around 6:50pm with the ambulance arriving shortly before 9:30pm. Mr Hamer was conveyed to Prince Charles Hospital in Merthyr Tydfil but despite treatment his condition deteriorated and he died there on the morning of the 10th February 2016.
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) As against an internal Welsh Ambulances Services Trust response target time for an Amber 2 call of 20 minutes, an ambulance did not arrive at the scene for nearly 2 hours and 40 minutes. It was accepted in evidence on behalf of the Welsh Ambulance Services Trust that this response time was unacceptable and that the situation *could happen again*.



	2) Cognisant of the delay in responding to the original call to the emergency services, good practice of the Welsh Ambulance Services Trust would have been to have made a phone call(s) to seek an update on the condition of the patient, to provide further advice and to ascertain whether it would have been appropriate to re-categorise the call. A call was not made to the family of the deceased (and this was disputed in evidence in any event) until just before 8:25pm, 1½ hours after the original call had been received. 3) The evidence suggested that at or around the time of the first call being made to the Welsh Ambulance Services Trust at around 6:50pm on the 8th February 2016 there was an extremely high number of calls being *polled.* The evidence suggested that there was an absence of clear planning and direction as to the maintenance and delivery of the Trust's services and that in repeat circumstances of such significant *polling* the same circumstances as found at the inquest of Mr Hamer could repeat themselves.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 15th June 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, The Welsh Ambulance Services Trust, Health Inspectorate Wales, the family and the Minister for Health & Social Services who may find it useful or of interest. 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	**20th April 2016 SIGNED:**