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. Chief Executive of the Welsh Ambulance Trust** **2. Chief Executive of the ABMU Health Board**
1	**CORONER** I am Andrew Barkley, Senior Coroner, for the coroner area of South Wales 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 19th January I commenced an investigation into the death of Anton Kusz aged 88. The investigation concluded at the end of an inquest of the 25th of April. The conclusion of the inquest was a narrative conclusion as follows "Anton KUSZ died from natural causes aggravated by the effects of a fractured neck of femur caused when he fell at his Care Home on 5th January 2017 and which was operated on 6th January 2017."
4	**CIRCUMSTANCES OF THE DEATH** The deceased resided in a Care Home and suffered a fall at breakfast on the morning of the 5th January falling and fracturing his right hip. He was eventually conveyed from the care home to the Princess of Wales Hospital where the following day he underwent surgery to repair the fracture of the hip and passed away the following day on the 7th January having sustained a sudden cardiac arrest.
5	**CORONER'S CONCERNS** During the course of the inquest, and the investigation leading up to it, 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 **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) There was a delay of over eight hours before an ambulance crew was able to convey Mr Kusz to the hospital. The initial 999 call was made at 0822 hours and was then chased on at least seven different occasions by the care home and also his General Practitioner

	who saw him in the position in which he fell 5 hours after the fall. The evidence revealed that the General Practitioner reported an occasional irregular heart beat and asked that an urgent ambulance was sent. It was not until 1447 that a Clinician, employed by the Ambulance Service reviewed and undertook a secondary triage of Mr Kusz's case which escalated his status to a more urgent case which, if known before may have resulted in an earlier response. The evidence went on to reveal that at that time there were just three Clinicians employed by the Welsh Ambulance Service reviewing all 999 calls for across Wales. One of the main factors accounting for the significant delay was the unavailability of resources/ambulances caused by extensive delays at hospitals across the region handing over patients at Accident and Emergency Departments. Delays of three to four hours were widely reported when the optimum period of time is fifteen minutes. This was so even though the escalation policy to "level three" (indicating severe pressure on the system) was in operation. Whilst the evidence was equivocal as to whether the delay had directly led to Mr Kusz's death the fact that an 88 year old gentleman with a serious injury such as a fractured hip had to remain on the floor in the same position in pain for over eight hours raises a real concern for the safety of others.
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 22nd June 2017. 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 Assembly Government and the family 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	**27th April 2017** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**