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. Welsh Ambulance Service NHS Trust**
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 25th June 2018 I commenced an investigation into the death of Andrew Collins. The investigation concluded at the end of an inquest on the 26th September 2018. The conclusion from the inquest was that of "*Natural Causes*".
4	**CIRCUMSTANCES OF THE DEATH** On the 6th June 2018 the deceased became acutely unwell at his home address with a sudden onset of severe headache. He deteriorated rapidly and became unconscious. On admission to the University Hospital of Wales in Cardiff scanning revealed a subdural haematoma. He underwent emergency neurosurgery to evacuate the haematoma, never recovered and passed away on the 16th June. He was on life time anticoagulation for atrial fibrillation. He was anticoagulated with warfarin. It was alleged that he was subject to an assault in which he was struck to the head with a bar on or around the 27th May. The evidence both from clinician and pathologist failed to make a link between the assault and the bleed. The evidence indicated that the bleed was far more recent and likely to have commenced seventy two hours before his admission to hospital on the 6th June.
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 some 3 hours in sending an ambulance to Mr Collins when it was clear that his clinical picture was rapidly deteriorating.

	The first 999 call was received at 16:10 on the 6th June and correctly categorised but no vehicle was available to be dispatched to assist him. A further 999 call was made by his partner at 18:09 and again at 18:55 at which point he was described as "just about breathing and just about conscious". An ambulance became available and was on scene at 19:10. He was conveyed to the University Hospital of Wales at 20:08 and handed over to hospital staff at 20:26. Whilst the evidence suggested that the calls to the ambulance service were correctly categorised as having urgent clinical priority a clear lack of resources meant that there was a significant delay in attending to a critically unwell and deteriorating patient which, in my opinion must create a risk that further deaths may occur.
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 27th November 2018. 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 Minister of Health 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	**2nd October 2018** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**