

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. Chief Executive, Welsh Ambulance Trust, Ty Vantage Point, Vantage Point House, Ty Coch Way, Cwmbran, NP44 7HF</p>
1	<p>CORONER</p> <p>I am Jonathan Mark Layton, Senior Coroner, for the coroner area of Carmarthenshire and Pembrokeshire.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 16th May 2018 I opened an inquest into the death of Michael Jonathan Davies following concerns from his family that a delay on the part of the Welsh Ambulance Service in attending at his home in response to a call had been a contributory factor in his death. The inquest concluded on the 22 February 2019 when I recorded a narrative conclusion that "Michael Jonathan Davies died on the 7th February 2018 at his home address from an acute myocardial infarction. There was a delay in providing medical treatment which may have been a contributory factor in his death".</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>(1) On the 7th February 2018 Michael Jonathan Davies, aged 52, began complaining of pains down his arms and back. He telephoned the emergency services for an ambulance. The call was processed using the Medical Priority Dispatch system and categorised as Amber 1 which is the highest categorisation that can be given to a patient who is conscious and breathing. The inquest heard that the response time for an Amber 1 categorisation is up to 4 hours. Shortly after making this call Mr Davies became unresponsive and a further call was made by his father. As Mr Davies was now unconscious the call was categorised as Red with a response time of 8 minutes. Upon arrival of the ambulance service Mr Davies had passed away.</p> <p>(2) Evidence was before the inquest that a prompter response to the initial call made by Mr Davies may have prevented his death.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed this matter 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.</p>

	<p>THE MATTERS OF CONCERN are as follows:</p> <ol style="list-style-type: none"> 1. During the course of the inquest the Welsh Ambulance Service Trust disclosed that in 2015 chest pains and related conditions were removed from the Red categorisation and placed in an Amber 1 categorisation whenever the patient is conscious and breathing. The inquest heard that in England (or in parts thereof) chest pains and related conditions remain as attracting a Category Red response. 2. The effect of removing chest pains and related conditions from Category Red is the response time, previously 8 minutes, is now up to 4 hours and often patients are advised to make their own way to hospital. 3. This puts patients' lives at risk and in this inquest may have contributed to the death of Mr Davies.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by the 20 June 2019. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Person:</p> <p style="background-color: black; color: black;">[REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>25 April 2019 Signed:</p>