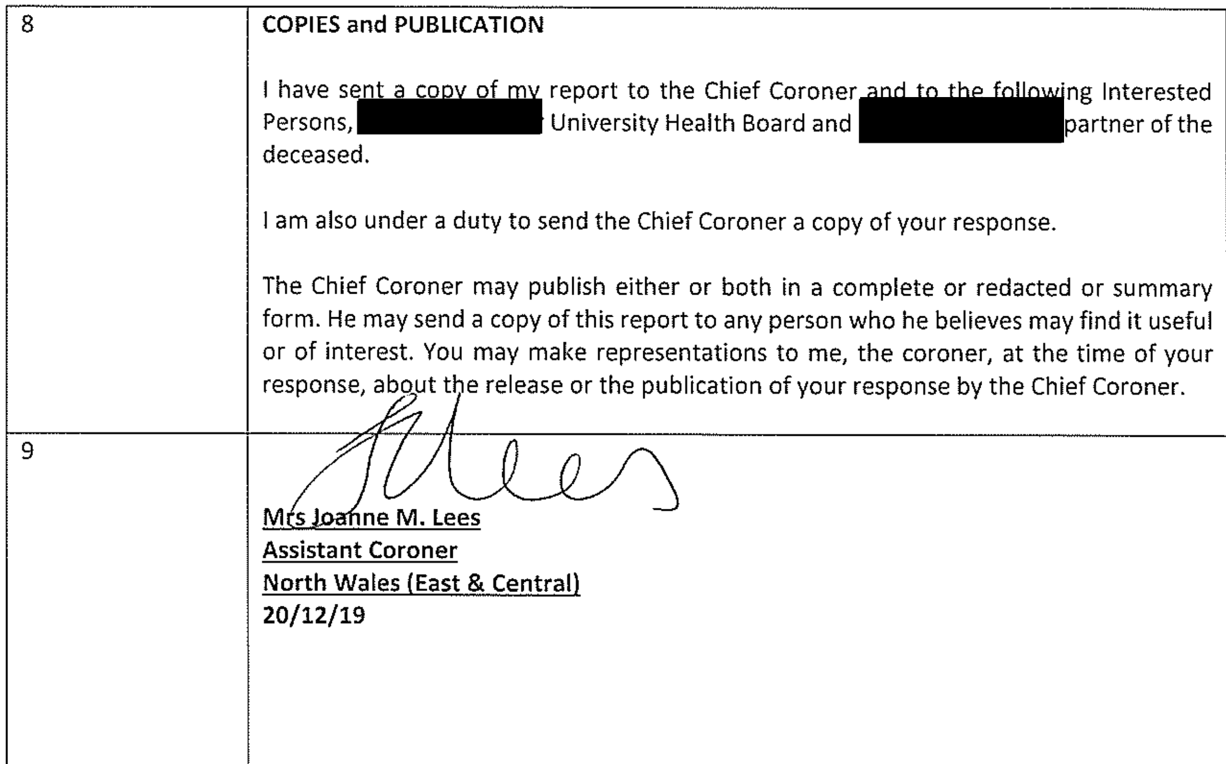
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1.Welsh Ambulance Services NHS Trust, HM Stanley Site, St Asaph, Denbighshire LL17 0RS
1	**CORONER** I am Mrs Joanne Lees, Assistant Coroner, for the coroner area of North Wales (East & Central).
2	**CORONER'S LEGAL POWERS** 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 1/3/18 I commenced an investigation into the death of Samantha Brousas who died on the 23rd February 2018 at Wrexham Maelor hospital. The investigation concluded at the end of the inquest on 20/12/19. The Coroners conclusion was a narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** The deceased became ill in the winter of 2018. She visited her gp practice twice before consulting with her gp on 20/2/18 with symptoms of diarrhoea and vomiting and was diagnosed with gastric flu. By the following day she had significantly deteriorated with a high temperature and difficulty slowing her breathing down. An ambulance was called at 15:33 arriving at her home address at 16:45 by which time she had a NEWS score of 13, suspected sepsis and was critically ill. There was no pre alert to the hospital. The ambulance arrived at the ED at 17:29 and the deceased was held outside receiving fluids, oxygen and paracetamol without being triaged. She was admitted into the ED at 19:40. The ED was in escalation and operating at the highest level of extreme pressure. Within an hour of being admitted into the ED the deceased received antibiotics and supportive care having been diagnosed with septic shock secondary to pneumonia. Sadly, she failed to respond to treatment, she deteriorated and passed away on 23/2/19 from a naturally occurring infection. I concluded that none of the above facts affected the outcome.
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) During the course of the inquest I heard evidence that the two paramedics who attended the home address of the deceased identified her as having a NEWS score of 13 with suspected sepsis. Both paramedics made a joint decision not to pre alert the

	emergency department at Wrexham Maelor hospital whilst being aware that there were already ambulances waiting outside the emergency department. I heard evidence that this was against the Joint Royal Colleges Ambulance Liaison Committee (JLARC) clinical guidelines that if sepsis is identified an alert SHOULD be made. At that time the Welsh Ambulance Service Trust (WAST) had in effect a Clinical Notice regarding the use of the ASCHICE mnemonic but not the circumstances under which it was to be used creating room for discretion to be exercised. It was accepted as part of a WAST investigation that a pre- alert should have been used. My finding on the evidence was that '*the absence of a pre alert meant that the ED had no opportunity to prepare for Sam's arrival and there could have then been no doubt as to the severity of her illness or her condition' and 'it would least have had the effect of alerting the department that a critically unwell patient was on their way and enabling them to make efforts to find or make a bed for (the deceased).* To be clear my finding was that the absence of a pre alert did not affect the outcome. I heard evidence that in December 2018 WAST issued a further clinical notice clarifying the expectations for the use of the pre alert but this fell short of a mandatory requirement for a pre alert for suspected sepsis. My concern is that this creates a discretion which is not compatible with the JLARC guidelines and may result in a similar situation where a pre alert is not used in a life threatening time critical situation as happened with the deceased, which may present a risk to life. (2) I heard evidence during the course of the inquest that the first line treatment for sepsis was the administration of anti-biotics within an hour of arrival at a hospital consistent with the SEPSIS SIX and NICE guidelines. I also heard evidence that it was currently beyond the scope of the practice of WAST paramedics to administer antibiotics intravenously in an ambulance. Given the importance of the role of the Paramedic in the early diagnosis of Sepsis my concern is that when a patient is unable to be admitted into the emergency department in similar situations as the deceased, the absence of the administration of antibiotics increases the mortality risk of such patients which could be addressed by exemptions and local organisational level policies and procedures. (3) During the course of the inquest I heard evidence that both paramedics attending the deceased had significant concerns about both the patient's condition and the delay in admission into the ED. Despite these concerns, neither paramedic escalated these concerns either through Ambulance Control or through hospital escalation channels (which were known to Ambulance Control). My concern is that there was an absence of a policy or procedure whereby staff could escalate such concerns thereby missing an opportunity to highlight individual cases requiring immediate escalation in the absence of any clear management plan for the patient's admission.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 14/2/20. 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, University Health Board and partner of the deceased. 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	**Mrs Joanne M. Lees** **Assistant Coroner** **North Wales (East & Central)** **20/12/19**