Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Wales Ambulance Service NHS Trust
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 **3/8/21** an investigation was opened into the death of **Barbara YOUNG** The investigation concluded at the end of the inquest on: **25/1/22** The conclusion of the inquest was recorded as: **Death by Accident** The medical cause of death was: **1a Bronchopneumonia** **1b Multiple Rib and Spinal Fractures** **1c Fall down stairs** **2 Head Injury**
4	**CIRCUMSTANCES OF THE DEATH** Barbara Young fell downstairs at her home address on 15th July 2021. She sustained multiple injuries including fractures of her ribs, spine and skull. Barbara was taken to hospital where, due to her reduced mobility, she developed pneumonia. The combined effects of trauma and pneumonia proved overwhelming, and Barbara died at the University Hospital of Wales, Cardiff, on 23rd July 2021.

5	**CORONER'S CONCERNS** During the course of the inquest, 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: - Barbara Young fell at home on 15/7/21 at approximately 11:30hours. Her family immediately called the emergency services and informed the ambulance call handlers that she had fallen downstairs, was not fully conscious and had sustained an apparently severe head injury. An ambulance arrived at 14:26 hours. Mrs Young was taken to hospital where she was diagnosed with multiple injuries including an intracranial bleed, rib fractures, a pneumothorax and a fractured clavicle. Given the nature of Mrs Young's injuries, her frailty and trauma- induced immobility, she developed pneumonia which was ultimately the cause of death. I am informed that the risk of mortality in the elderly who have suffered significant trauma is high, because they are at greater risk of developing pneumonia. It is therefore essential that they receive emergency medical care as soon as possible. In this case it took 3 hours for an ambulance to arrive and whilst I have no evidence that this delay contributed to Mrs Young's death similarly I cannot confirm it did not, and that future lives could be at risk due to the delays in providing a timely emergency response. I acknowledge the problems faced by the ambulance service over the last 2 years, problems that have been compounded by the effects of the pandemic and delays in transferring patients into hospital emergency departments. I have also been informed that there have been plans in place to improve the responsiveness of the service however from the evidence provided at this inquest it appears that problems still exist.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. <u>I should be grateful if the following information be provided to me:</u> 1. Confirm the action that will be taken to improve the response times of emergency ambulances. 2. Confirm whether there are any plans to review the categorisation of elderly patients who suffer falls and are more likely to be affected by the risks associated with lengthy periods of immobility.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 25/03/22, I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) The family of Barbara Young Health Inspectorate Wales. 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 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	**DATE 28/01/22** Signed C Saunders. Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**