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. The Chief Executive of 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 3/6/21 an investigation was opened into the death of **Gwynne SAMUEL** The investigation concluded at the end of the inquest on: **16/6/22** The conclusion of the inquest was recorded as: **Death by Accident .** The medical cause of death was: **1a) Chest infection** **1b) Hip fracture (operated) and long lie** **2 Chronic kidney disease , Frailty of old age, Ischaemic Heart Disease**
4	**CIRCUMSTANCES OF THE DEATH** Gwynne Samuel (GS) was a 95-year-old gentleman who lived alone. On 10/5/2021 he suffered a fall at home. GS was experiencing pain, a swollen neck and was bleeding. His daughter discovered him and called for an ambulance at 19:53 on 10/5/21. An ambulance eventually arrived at 07:36 on 11/5/21. GS was admitted to the Grange University Hospital, Llanfrechfa, where he was diagnosed with a fractured neck of femur. GS was in a poor condition and the evidence heard at the inquest confirmed that he had suffered an acute kidney

	injury caused by rhabdomyolysis. Rhabdomyolysis is directly attributable to the long lie GS had experienced whilst waiting for an emergency ambulance. As a result, the necessary operation on his hip was delayed until 13/5/21, by which time he was developing a chest infection. Post-operatively GS went into a further decline and was overwhelmed by pneumonia. He died on 20/5/21.
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: - GS was an elderly gentleman who had suffered a significant fall. The time it took for an ambulance to arrive and convey him to hospital contributed to his death insofar that the development of an acute kidney injury, which compromised his treatment and general condition, was caused by a long lie. A report obtained from WAST indicated that GS had been categorised as an Amber 2, which I understand is an urgent clinical priority considered serious but not life threatening. Whilst I accept that there was no evidence that GS was in immediate peril, it would appear that the clinical ramifications of an elderly person lying for a long period of time are not taken into account during the categorisation process. Whilst I heard evidence, and understand, the pressures on the ambulance service during the pandemic and the inability to release emergency ambulances due to congestion in hospital emergency departments, the inability to provide an ambulance to a patient determined to be in a serious condition (Amber 2) for 12 hours, puts lives in danger and, as in this case, may contribute to their death.
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. Confirmation whether the effect of long lies in elderly patients is understood and taken into account during the categorisation process. 2. Confirmation of the current average waiting times for Amber 1 and Amber 2 responses and any plans in place to improve responsiveness.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 09 August 2022, 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 Gwynne Samuel Health Inspectorate Wales. Minister of Health for 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 17/6/22** Signed Saunders . Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**