REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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THIS REPORT IS BEING SENT TO: 1. Cardiff & Vale University Health Board NHS Trust; 2. Welsh Ambulance Services Trust.

1. CORONER

   I am Dr. Sarah-Jane Richards, HM Assistant 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 9 July 2021 I commenced an investigation into the death of MARIA IMMOCALATA WHALE. The investigation concluded at the end of the inquest on 27 October 2022. The medical cause of death provided was: 1(a) Pelvic Haemorrhage and Abdominal Wall Haematoma. The Coroner's conclusion at the end of the Inquest was: *Natural causes where a lack of response by the Out of Hours GP service and a significant delay in attendance by the ambulance services may have influenced her survival.*

4. CIRCUMSTANCES OF THE DEATH

   These were recorded as:-

   Maria Immocalata Whale, 67 years, suffered a fatal pelvic haemorrhage and abdominal wall haematoma whilst at her home address of 60 Thornhill Road, Cardiff, South Wales on 29 June 2021. The symptoms of abdominal pain had been increasing over the previous two days. The Out of Hours GP Service was unable to assist when called at 01.50 hours on 29 June 2021 and again later. Thus, the ambulance service was called shortly afterwards and several times over a period of two hours or so but did not attend until Maria Whale was declared life extinct.

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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 those MATTERS OF CONCERN which are as follows:-

   (1) The University of Wales Accident and Emergency Department is only 2.1 miles from the home address of Mrs. Immocalata Whale and her husband, [redacted]. Mrs. Whale was disabled and needed a hoist to access their car. [redacted] was unsteady

on his feet. The grave condition of Mrs. Whale that night meant it was impossible for [redacted] to transport her to A&E. Similarly infeasible, was the advice of the Out of Hours triage nurse, Joanna Guy to call a taxi. She later suggested [redacted] should call 999.

(2) During the repeated calls to the 999 Emergency Services, [redacted] was advised the following:

i) there were no resources available;
ii) Mrs. Whale did not meet the criteria to have an elevated priority status; and
iii) when asked to define the degree of pain suffered on a scale of 1-10 Mrs. Whale (who was screaming in agony) responded "11". [redacted] stated in Court under oath that the call responder concluded that if Mrs. Whale could scream then she was not a priority. Within an hour of this conversation Mrs. Whale had died without any emergency support and in agony.

[redacted] Clinical Director of Cardiff and Vale UHB Urgent Care Service confirmed in Court that the Out of Hours (OoH) GP service had two GPs on duty that night – one of whom was attending a patient while the other was assisting the triage nurses. It was also confirmed that for the period during which [redacted] had called the OoH service, the numbers of calls were comparatively low.

Under oath, Dr. [redacted] stated that the advice given to [redacted] by the triage nurse was correct – either to take Mrs. Whale to hospital by taxi or call 999. He confirmed that the triage nurse had recognised Mrs. Whale was gravely ill. He disagreed that the second GP should have attended Mrs. Whale saying that the GP could neither have assisted with the diagnosis nor with accessing emergency transport to hospital by advising the 999 service of the urgency of the need for hospital admission. Pain relief provision by the OoH GP service was not mentioned.

Dr. [redacted] was adamant that an OoH GP would have been unable to expedite Mrs. Whale's access to hospital even though the gravity of her condition was accepted. He was similarly adamant that a GP attending Mrs. Whale would not have been able to communicate the gravity of her condition to the emergence services any better than a lay person - in this case the distressed husband. Again, provision of pain relief was not mentioned.

The 999 Emergency Service triage patients for priority depending on the response provided by a person close at hand to the patient, to a series of scripted questions. The Welsh Ambulance Service Trust has advised the following:

- Red calls are the highest clinical priority and are deemed immediately life threatening e.g. cardiac arrest;
- Amber 1 calls have a high clinical priority and are still considered a life threatening emergency e.g. chest pain;
- Amber 2 calls have urgent clinical priority, are serious but not considered immediately life threatening, for example diabetic problems; and
- Green calls are not considered to have urgent clinical priority and are not considered serious or life threatening.

[redacted] in responding to these questions was advised his wife was not a priority. Clearly, the triage questionnaire did not adequately measure the gravity of Mrs. Whale's condition, as within two hours of being graded a 'non-priority' she was declared life extinct.

6. ACTION SHOULD BE TAKEN

It is my opinion in order to prevent future deaths occurring, the triage systems of both the OoH GP Service and the 999 Emergency Service of the Welsh Ambulance Service Trust, need to be reviewed so that others, like Mrs. Whale whose life was on a knife's edge, are not erroneously overlooked as a medical priority.

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 January 2023 (taking into account statutory holidays). I, the Coroner, may extend the period upon request. 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 family ([redacted] spouse of the deceased) who may find it useful or of interest and The Minister for Health and Social Services of 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 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 November 2022

SIGNED:

HM Assistant Coroner for South Wales Central