	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Welsh Ambulance Service NHS Trust (WAST) [redacted], Minister for Health and Social Services
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 11/04/2022 an investigation was opened into the death of Dorothy Anne Jones The investigation concluded at the end of the inquest on: 17/01/2023 <u>The conclusion of the inquest was recorded as:</u> A narrative conclusion in the following terms: *Dorothy Anne Jones died at home on 29/03/22 from the effects of bronchopneumonia. Her death was contributed to by the failure of Welsh Ambulance Services NHS Trust to convey Mrs Jones to hospital within a reasonable timescale as dictated by her poor clinical condition*. <u>The medical cause of death was:</u> 1a Bronchopneumonia 2. Advanced multiple Sclerosis
4	**CIRCUMSTANCES OF THE DEATH** On 22/03/22, Dorothy Anne Jones developed a chest infection. After failing to respond to antibiotics, she was seen at home by [redacted] her GP on 29/03/22. [redacted] considered that Mrs Jones needed to be admitted immediately to hospital. Mrs Jones had low oxygen levels and was drowsy and [redacted] requested that an ambulance attends within 2 to 3 hours. Following discussion with the ambulance service they informed [redacted] that there was a 2- 4 hour wait but that they would attempt to send an ambulance quicker. Unfortunately, the pressure on the ambulance service and a failure to identify an earlier available resource meant that paramedics did not attend until 20:28, over 9 hours later.

	On arrival, paramedics confirmed that Mrs Jones had died and could not be revived. On hearing the evidence, I determined that a failure to send an ambulance within a timescale required by the severity of Mrs Jones's illness, contributed to her death.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - 1. The ongoing pressures faced by the ambulance service are clearly multifactorial. However, a failure to provide a resource within a reasonable timeframe has been a constant and ongoing feature of inquests within Gwent, where a patient has died at home or shortly after admission to hospital. Despite repeated reassurances over the past 12 months about remedial action being undertaken, the evidence before me at this inquest suggests there has been no appreciable improvement in the response times for Amber 1 category patients. 2. The Amber 1 category includes all life-threatening conditions except those in the Red category where the person appears to be in the throes of dying. I was informed that all the patients in the Amber 1 category are allocated an ambulance / clinical resource chronologically, without further consideration of clinical need. 3. I was informed at the inquest that on occasion a clinician within WAST will intervene to undertake a further assessment to determine whether the response should be expedited. However, this appeared to be an ad hoc arrangement not underpinned by local policy or guidelines. 4. The evidence suggested that a patient who was choking, had difficulty breathing and was drowsy would still be assessed, under the current algorithm adopted by WAST, as meeting the requirement for an Amber 1 response.
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. The steps being undertaken on a national and local level to address the delays in ambulance response times, particularly within the Amber 1 category. 2. Whether consideration can be given to undertaking a more detailed clinical assessment of the patients within Amber 1 to ensure those in the greatest need for clinical intervention are given priority. 3. The process for reassessment of the patient's clinical condition during the time they are waiting for an ambulance. 4. Confirm whether the national algorithm adopted by WAST is fit for purpose and that there is provision to identify life-threatening scenarios, where a patient may quickly deteriorate from an Amber 1 into a Red.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 17/03/2023 . 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 Dorothy Anne Jones 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: 20/01/2023** Signed:  Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**