John Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Welsh Ambulance Services NHS Trust, Ty Elwy, Unit 7 Richard Davies Road St Asaph Business Park, St Asaph, Denbighshire LL17 0LJ
1	**CORONER** I am John Gittins, Senior Coroner for North Wales (East and 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 the 16th of June 2022 an investigation was commenced into the death of Rashdah Waseem Begum Bhatti (DOB 19/05/45) who died at her home in Prestatyn on the 14th of June 2022. The conclusion of the inquest on the 11th of September 2023 was by way of a narrative conclusion in the following terms : "On the 14th of June 2022 at her home, the deceased began haemorrhaging from her varicose veins and although ambulance assistance was requested, there were no resources available to respond for some hours. This resulted in a delay which denied Mrs Bhatti timely and potentially life preserving treatment and she was pronounced dead at the scene at 21.15 hours"
4	**CIRCUMSTANCES OF THE DEATH** As detailed in the narrative conclusion the deceased began bleeding from varicose veins and the extent of the haemorrhage was exacerbated by her being on anticoagulants. An initial 999 call was made at 18.25 and over the course of the next two hours there were a further six calls made before a response was allocated, with the first ambulance arrival on scene at 20.36.
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. –

	The Trust utilises the Medical Priority Dispatch System (MPDS) and there are specific instructions within the same in relation to a varicose vein bleed namely "Elevate the affected leg/arm (above heart level on a cushion pillow or other soft object" Although from the outset this was recognised to be a varicose vein bleed, this advice was not given in at least two of the first four calls due to human error and it appears from the evidence that until the 5th call was made at 20.04, that no such clinically beneficial advice was given to those family members who were attending to the deceased. Evidence was provided that a memo/reminder had been issued to staff regarding this error, however there was no evidence as to the effectiveness of such a reminder in the reduction of human error and I am concerned that deaths may occur as a result of failures to provide advice available within MPDS due to handlers not following the correct/most appropriate pathway.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 7th November 2023. I, John Gittins, 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 Family of the Deceased and to the Chief Coroner. 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	Dated 12th September 2023  Signature Senior Coroner for North Wales (East and Central)