GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

[redacted]

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **WELSH AMBULANCE SERVICE NHS TRUST**
1	**CORONER** I am Patricia Morgan Area 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 5 November 2021 I commenced an investigation into the death of Brian JAMES . The investigation concluded at the end of the inquest on 11/01/2024. The conclusion of the inquest was Mr James died following a fall at his home. A delay in ambulance response and admission may have affected the treatment available to Mr James. Medical Cause of Death:- **1a Cerebral Haemorrhage Following Fall** **1b** **1c** **II**

4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Brian JAMES aged 91 years suffered a Cerebral haemorrhage following fall at home. He lived at home with his brother. He got up in the night to pass water due to his overactive bladder and fell out of bed. He hit his head (suffered abrasion) he did not lose consciousness and was alert and talking when police and fire came to assist as his brother could not get him back into bed. Ambulance was contacted however there was a delay of around 9 hours until their arrival. Ambulance crew came to do a courtesy visit the following morning and he was found in bed GCS 3 and covered in his own vomit. CT head showed cerebral haemorrhage. CT head findings discussed with neurosurgeons who said this man would not be for surgical intervention He sadly passed away in hospital on 1st November 2021. The Inquest focused upon:- (i) The events of 30 October 2021 and leading to admission (ii) whether any delay in admission to hospital and medical treatment was causative (more than minimally contributory) to death.
5	**<u>CORONER'S CONCERNS</u>** 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. (1) A script used by Operators within WAST as part of the Clinical Safety Plan inform callers not to call back for an estimated time of arrival of the ambulance. They are told to *only* call back if there is a deterioration in the patient's condition. (2) During periods of a delayed response from an ambulance, WAST best practice is for an Operator to maintain regular contact with callers to assess any change in their condition. During periods of excessive demand, it is considered that this is not always achievable, and therefore Welfare calls are prioritised to callers considered vulnerable. (3) There may be a risk that callers do not understand the instruction to *only* call back if there is a deterioration, and/or may not recognise a deterioration, and feel they cannot call WAST again. There is a further risk that unless regular welfare calls are made during periods of delayed response, there is a missed opportunity to properly re-assess and re-grade the response to a call by WAST.
6	**ACTION SHOULD BE TAKEN**

[redacted] [redacted]

	In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 by 4 April 2024. I, 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 family who may find it useful or of interest. 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	7 February 2024 **SIGNED:**  Patricia Morgan Area Coroner for South Wales Central Coroner Area

[redacted] [redacted]