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:** **Minister for Health and Social Services, Welsh Government**
1	**CORONER** I am Gavin Knox, 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 22 July 2022 an investigation commenced into the death of Joseph Leonard Scott Cattle. The investigation concluded at the end of the inquest 24/01/2024. The conclusion of the inquest was: Alcohol related.
4	**CIRCUMSTANCES OF THE DEATH** Mr Cattle contacted WAST at 0044 who categorised the call as requiring an Amber 1 response. There were 2 further calls between Mr Cattle and WAST at 0117 and 0325. Paramedics did not attended until approximately 0720 by which time Mr Cattle was deceased.
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) Welsh Ambulance Service Trust were unable to allocate an available ambulance resource in an Amber 1 category call until over 6 hours from the time of the 999 call; (2) Despite having their full complement of ambulance resources staffed and on shift many of them were held up by delays in handover at hospitals; (3) The number of funded ambulances appeared to be significantly short of what would have been needed in the circumstances.
6	**ACTION SHOULD BE TAKEN** 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. In particular you are asked to consider: 1. what funding, guidance and targets are being provided to public bodies (WAST, Local Health Boards and Local Authorities) with a view to reducing hospital handover delays. This necessarily includes consideration of the full patient flow from ambulance to hospital discharge; 2. How Welsh Ambulance Service Trust is funded and whether this can or should be increased or managed in a different way.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th 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: • Mr Cattle's family • Welsh Ambulance Service Trust 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	22 February 2024 **SIGNED:** 

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

Phone/Ffôn (01443) 281100 Fax/Ffacs (01443) 485862

	Gavin Knox, Assistant Coroner for South Wales Central Coroner Area

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