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:** 1. [redacted] **– Chief Executive of the Welsh Ambulance Service Trust** 2. **Chief Executive of Aneurin Bevan University Health Board** 3. **Eluned Morgan – Minister for Health & Social Services**
1	**CORONER** I am **Graeme D Hughes, Senior 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 13 February 2023, I commenced an investigation into the death of Lynda BLACKMORE. The investigation concluded at the end of the inquest on 1st November 2023. The conclusion of the inquest was: - **The deceased died due to overwhelming infection, on a background of chronic and deteriorating significant natural disease.** I determined the medical cause of her death to be:- **1a Sepsis** **1b Leg cellulitis due to chronic leg oedema** **1c Congestive cardiac failure** **II Type 2 diabetes mellitus, ischaemic heart disease**
4	I recorded the following in respect of How, When and Where she came about her death:- Lynda Blackmore had established heart failure and diabetes mellitus. In early 2023 there was a further deterioration in her symptoms leading to a painful, bruised and swollen left leg. On 1st February 2023 she became acutely unwell and her GP attended upon her at her home. This led to an emergency call to the ambulance service for urgent conveyance to University Hospital Wales, Heath for specialist vascular treatment. There was a delay in the arrival of the ambulance of some thirteen hours likely due to a combination of mis-categorization of the response, resource availability and hospital handover delays. By the time of her arrival she was diagnosed with sepsis. Whilst treatment was initiated, she did not respond and died there later the same day. The delay in the instigation of necessary treatment likely contributed to her 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:- The investigation focused upon the causal significance, if any, of a delay of some thirteen hours, or thereabouts in the provision of an ambulance to the deceased. I received written & oral evidence from Andrew Garner of the Welsh Ambulance Service Trust (I annex a copy of his witness statement). I refer you in particular, to paragraph's 43-49. My concern here is that handover delays are impacting upon response times in respect of patients requiring emergency treatment &/or conveyance to hospital. As Mr Garner stated in his evidence at para 45, the handover delays experienced at/around the time that the

	deceased was awaiting assistance were well in excess of the targets enshrined in the Welsh Health Circular of May 2016. Such delays pose a risk to the lives of those requiring emergency treatment/conveyance to hospital.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th January 2024, or if I, the Coroner extends 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 proposed. **Whilst this Report is directed individually to each of those listed above, I consider it desirable, given the *interweaving* nature of the matters of concern, that the response be a collaborative one**
8	**COPIES and PUBLICATION** I have sent a copy of my report to family 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	15th November 2023 **SIGNED:** 

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

	Graeme D Hughes, Senior Coroner for South Wales Central Coroner Area

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