REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** CHIEF EXECUTIVE SWANSEA BAY UNIVERSITY HEALTH BOARD 1 TALBOT GATEWAY BAGLAN ENERGY PARK BAGLAN PORT TALBOT SA12 7BR CHIEF EXECUTIVE WELSH AMBULANCE SERVICE NHS TRUST BEACON HOUSE WILLIAM BROWN CLOSE CWMBRAN NP44 3AB
1	**CORONER** I am **Aled Gruffydd**, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 20th February 2023 I commenced an investigation into the death of Jean Thomas. The investigation concluded at the end of the inquest on the 29th February 2024. The medical cause of death is 1a Infected Sacral pressure sore associated with long lie and reduced mobility 1b) 1c) 2 Frailty of old age, previous stroke, fractured neck of femur (operated 16.12.22) The conclusion of the inquest as to how Mrs Thomas came to her death was a narrative conclusion and is as follows:- The deceased died of an infected pressure sore caused by a long lie whilst waiting for an ambulance following a fall at home and exacerbated by a delay in handing the deceased over to the Emergency Department and sourcing an anti-pressure sore mattress.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Jean Thomas who was pronounced dead on the 10th of February 2023 at Morriston Hospital, Swansea. The cause of death was an infected sacral pressure sore associated with long lie and reduced mobility. Jean was admitted to Morriston Hospital on the 14th of December 2022 after having suffered a fall at home on the 13th of December 2022. The fall occurred at approximately

	12:30pm on the 13th December 2022 and the ambulance arrived at 2:48am on the 14th December 2022, meaning that Jean had been on the floor for 14 hours during which time a pressure sore had begun to develop. Jean was taken to hospital but remained in the ambulance until 20:56. Jean suffered a fracture to the neck of her femur as a result of the fall and this was operated and repaired on the 16th of December 2022. Despite a pressure sore having begun to develop by the time of admission to hospital on the 14th of December, no airflow mattress was obtained until the 20th of December. Jean underwent treatment for the pressure sore as well as antibiotics to prevent infection. Whilst the pressure sore showed signs of improvement with treatment, the wound then deteriorated due to a failure in the seal of the vacumn dressing, resulting in the wound being contaminated. This contamination resulted in the pressure sore becoming infected and Jean passed away on the above date.
5	**CORONER'S CONCERNS** During the course of the inquest it was apparent that the pressure sore was caused by the long lie at home waiting for an ambulance, and then the sore would have been exacerbated by a further long wait in the back of the ambulance waiting to be offloaded into hospital. Issues regarding the treatment of the pressure sore was recognised by the Health Board, consisting of a delay in obtaining an appropriate anti pressure sore mattress and a lack of pressure sore assessment documentation and the issues regarding treatment have been addressed by way of appropriate learning outcomes and action plans. I am concerned that where vulnerable patients are left waiting for an ambulance then pressure sores can develop due to a long lie. I am further concerned that these sores can be exacerbated in cases where there is a delay in offloading patients into hospital where they can then be nursed on an appropriate anti-pressure sore mattress. Whilst I am aware that the issues raised above occur nationally and are not restricted to the areas that the Welsh Ambulance Service NHS Trust and Swansea Bay University Health Board cover, 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. There was a significant delay in getting an ambulance to Jean which resulted in a pressure sore forming due to long lie. That pressure sore was exacerbated by a further long wait to be offloaded into hospital. The time taken to offload was in excess of 16 hours, when the target offloading time is 15 minutes,
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 29 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 the Chief Coroner and to the following Interested Persons [redacted]

	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	**4 March 2024 ……**  **…….. [SIGNED BY CORONER]**