Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: <u>The Chief Executive of Aneurin Bevan University Health Board.</u>
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 18/09/2023, an investigation was opened touching upon the death of: Sylvia Eileen Evans The investigation concluded at the end of the inquest on 14/05/2024 <u>The conclusion of the inquest was recorded as:</u> Death by Accident. <u>The medical cause of death was:</u> 1a) Ischaemic heart disease 1b) Coronary Artery Disease 1c) 2 Blood loss from leg wound. Atrial Fibrillation (on anticoagulants)
4	**CIRCUMSTANCES OF THE DEATH** On 05/09/2023, Sylvia Eileen Evans sustained an accidental wound to her leg at home, which caused a severe haemorrhage. This in turn put pressure on her heart, the function of which was already compromised by extensive ischaemic heart disease. The effects were overwhelming and resulted in Sylvia's death on 06/09/2023 at her home address.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - Sylvia Evans suffered an injury to her leg which caused extensive blood loss. At 22:56 hours she called for an ambulance. The call ended abruptly, and the inquest

	determined that Sylvia was bleeding heavily and suffering the effects of heart failure exacerbated by severe haemorrhage, which caused her to end the call. The nature of her injuries had not been conveyed to the call handler. The correct procedure was adopted by the Welsh Ambulance Service and Sylvia was categorised as requiring an Amber 1 response. The inquest heard that Amber 1 is the second highest category, reserved for people wo are likely to be suffering from a life-threatening emergency. An ambulance eventually arrived at 07:45 on 06/09/2023. This was almost 8 hours and 49 minutes after the call was registered. Sylivia had died by the time the ambulance arrived. The reason for the delay was explored at the inquest and in part determined to be due to hospital handover delay.
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. Welsh Ambulance Service NHS Trust identified a number of initiatives they have implemented over the last few years to try and address the problem of long waits in the community. However, they are unable to influence what happens at a hospital where, repeatedly, ambulances are waiting for extended periods of time because patients cannot be moved into the Emergency Department. <u>I should be grateful if the following information be provided to me:</u> The problems with ambulance delays commenced during the Covid pandemic, and this court has previously been made aware of the action taken to address the problem of patient flow. However, the problem does not appear to be abating and I should be grateful if you would provide me with details as to how this is being addressed and future deaths avoided. Whilst there was insufficient evidence to determine that an earlier ambulance response **<u>would</u>** have saved Sylvia's life, clearly waiting extended periods of time are putting patients' lives at risk.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 15 July 2024. I, the Coroner, may extend 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) • The family of Sylvia Eileen Evans

	• Health Inspectorate Wales • Welsh Ambulance Service NHS Trust • Minister of Health for Wales 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 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	**DATE 20/5/2024** Signed:  Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**