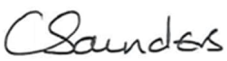
Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Cabinet Secretary for Health, Social Care and Welsh Language
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 25/9/2023, an investigation was opened touching upon the death of Marjorie Joyce Michael The investigation concluded at the end of the inquest on 17/7/2024 <u>The conclusion of the inquest was recorded as</u> Narrative Conclusion: "Marjorie Joyce Michael fell at [redacted] residential home in Pontypool on 3/9/2023. Marjorie lay on the floor for over 14 hours waiting for an ambulance. She was eventually conveyed to hospital on 4/9/2023. The long lie resulted in the development of pneumonia and Marjorie died at Nevill Hall Hospital on 6/9/2023. Her death was contributed to by delayed ambulance response". <u>The medical cause of death was:</u> 1a) Hypostatic Pneumonia 1b) Fall, Long Lie 1c) 2 Type 2 Diabetes. Ischaemic Heart Disease.
4	**CIRCUMSTANCES OF THE DEATH** These are described in the Narrative Conclusion in Box 3.

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - Marjorie Joyce Michael (MJM) fell at her residential Home on 4/9/2023. Carers were correctly advised by the ambulance call handlers not to move her on the basis that this could worsen any injury she had sustained. As a result, MJM lay on the floor for over 14 hours waiting for an ambulance **As per the medical cause of death provided by [redacted], Senior Clinical Fellow at Nevill Hall Hospital in Abergavenny, MJM's death was directly attributable to the delayed ambulance response.** Despite ongoing attempts by Welsh Ambulance Service and Aneurin Bevan University Health Board, the delays in responding to emergency calls are not improving. Witness evidence confirmed the many initiatives undertaken by these services to improve ambulance response times but these continue to be undermined by the delay in releasing emergency ambulances from acute hospitals to attend emergency calls. Witness evidence also confirmed that despite these initiatives there was no appreciable reduction in the lengthy waiting times for Amber 1 and Amber 2 responses; which are categorised as potentially life-threatening emergencies.
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. A previous response to a Regulation 28 Report from Aneurin Bevan University Health Board also identified local initiatives that have been implemented, however the ambulance response times have not improved. Your welcome response to my Regulation 28 report made on 20/01/23 (your response date was 20/03/23) does not appear to have materially improved the situation in Gwent, and I therefore bring this matter to your attention for further consideration.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 20/09/24. 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 Marjorie Joyce Michael • Chief Executive of Aneurin Bevan University Health board • Chief Executive of Welsh Ambulance Service NHS 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 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 26/07/2024** Signed  Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**