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:** **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** [redacted] **DIRECTOR GENERAL FOR HEALTH AND SOCIAL SERVICES** **WELSH ASSEMBLY GOVERNMENT** **CATHAYS PARK** **CARDIFF** **CF10 3NQ**
1	**CORONER** I am **Aled Gruffydd**, Acting Senior 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 September 2021 I commenced an investigation into the death of Peter Parker. The investigation concluded at the end of the inquest on the 16th October 2024. The medical cause of death is 1a) haemorrhage from sharp force injury to right wrist including transection of right radial artery 1b) 1c) 2 The conclusion of the inquest as to how Mr Parker came to her death was a narrative conclusion and is as follows:- The deceased died of a haemorrhage from a transected radial artery caused by broken glass at home, contributed to by the significant delay in the arrival of the requested

	ambulance.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Peter Parker who was pronounced dead on the 11th of September 2021 at his home address of [redacted]. The cause of death was a haemorrhage from sharp force injury to right wrist including transection of right radial artery Peter sustained a laceration injury to his right wrist whilst at home after falling and cutting himself on broken glass. Peter dialled 999 for an ambulance at 9:19pm on the 10th of September 2021 and stated that he had cut a vein and blood was pumping out. Approximately 3 ½ minutes into the call, the line disconnected at the time when the call handler was attempting to give Peter advice on how to suppress the bleeding. The call-handler for The Welsh Ambulance Service Trust (WAST) made five attempts to reconnect the call and make welfare checks without success. The MPDS system in operation by WAST gave the call an Amber 1 priority meaning that the call would be dealt with in order of receipt after all the Red priority calls were cleared. The requested rapid response vehicle arrived at Peter's home at 6:30am on the 11th of September 2021 and with the assistance of Police access was gained to Peter's home at 7:00am. This was approximately 9 ½ hours after the ambulance was requested. Peter was pronounced deceased at the scene at 7:09am.
5	**CORONER'S CONCERNS** During the course of the inquest the reason given for the significant delay to respond to the call was ambulances waiting at Emergency Departments to hand over patients, meaning that the ambulances are not therefore responding to calls for assistance. The longest wait at the Emergency Department by an ambulance on the evening in question was 11-12 hours, which is the equivalent of a whole 12 hour shift where that ambulance was not responding to calls. The inquest heard evidence that when the MPDS system was introduced in 2015 it was envisaged that an Amber 1 priority call would be responded to in 20 minutes from the time of the call and that a person with a transected radial artery could expect to survive 30-45 minutes. Given that it was not feasible for Peter to transport himself to hospital, and Peter had not contacted his family for their assistance. I am concerned that the response time in this case was beyond the expected survivability of such an injury. The Amber 1 priority rating was by itself not incorrect but was inappropriate in the context of the time taken to respond to such priorities on the evening in question. I am further concerned that the reason for the delay was due to ambulances waiting to offload patients at hospitals, in accordance with the ambulance's duty of care, and therefore not responding to emergency calls as is their purpose. The **MATTERS OF CONCERN** are as follows. – 1. There was a significant delay in getting an ambulance to Peter which resulted in him dying from his injuries before assistance arrived. The time for survival of such injuries was 30-45 minutes, however the time taken to respond was in excess of 9 hours. Whilst there is no specific target for Amber 1 calls it was envisaged that when the system was introduced such calls would be responded to in 20 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 17 December 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	**22 October 2024 ……**  **…….…… [SIGNED BY CORONER]**