ANNEX A

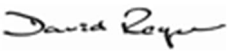
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive of the Cwm Taf Morgannwg University Health Board**
1	**CORONER** I am David Regan, Assistant 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** A Coronial investigation was commenced on 20th April 2022 into the death of Jackson Yeow, aged 16. The investigation concluded at the end of the inquest which I conducted on 15th -16th January 2025. The conclusion was a narrative conclusion and the medical cause of death was 1 (a) cerebral oedema, 1(b) diabetic ketoacidosis; 2 recent covid 19 infection; pancreatitis
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as: - Jackson Yeow, aged 16 years, suffered autistic spectrum disorder and obesity. On 28th March 2022 he was assessed by a general practitioner following a history of abdominal pain and vomiting, diagnosed with suspected gastritis, and treated. On 4th April 2022 his mother became concerned that his symptoms had worsened and sought the assistance of the general practice by telephone. Jackson was unable to mobilise to attend GP consultation in person and his mother phoned 999 at 12.13. Despite subsequent clinical support desk review and further 999 calls, an ambulance service resource was not allocated until after

	Jackson became unconscious at about 19.30, attending at 20.00. Jackson was subject to a prolonged extrication from his house with fire service and EMERTS assistance, was intubated and taken to the University Hospital of Wales where he was diagnosed to be suffering diabetic ketoacidosis, pancreatitis, cerebral oedema, renal compromise and severe acidosis. Despite intensive treatment over the subsequent days his condition deteriorated and he died on 9th April 2022. The narrative conclusion which I returned was: Jackson Yeow, aged 16, died of diabetic ketoacidosis following a wait for an ambulance of approximately 9 ½ hours. The Inquest focused upon: - a. The fact that Jackson Yeow's condition deteriorated on 4th April 2022. His family contacted his GP and was offered a face to face appointment which he became physically unable to attend. b. His family telephoned 999 at 12.13 on 4th April 2022. c. The ambulance service categorised the call as an amber 1 response, which it characterised as a life threatening call requiring an urgent response. d. The evidence of the ambulance service was that its ability to respond to the call was substantially impaired by the fact that a significant number of its resources were delayed at hospitals awaiting hand over of patients. e. An ambulance did not attend until 20.00 on 4th April 2022, by which time Jackson Yeow had suffered a substantial metabolic derangement, cardiovascular collapse and renal impairment. He was severely acidotic. f. The first language of the family was not English. Although some clinicians were able to use the services of an interpreter, this was not always employed.
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. –

	Although the Cwm Taf Morgannwg University Health Board did not provide direct care to Jackson Yeow during the period within scope, it provided the evidence of a consultant in emergency medicine to the inquest on the issue of delays in ambulance handovers at the Princess of Wales Hospital, Bridgend. That evidence directly identified the following matters of concern: (1) Care for patients in the emergency department is frequently provided in the corridor and other non clinical spaces, which: (a) Impedes efficient clinical assessment, causing clinicians to take longer performing tasks and rendering clinical care more difficult; (b) Impedes the ability of staff to recognize a patient's deteriorating condition; (c) Increases patient morbidity through environmental factors compromising a patient's ability to sleep, hygiene and nutrition. (d) May slow the process of ambulance handovers. (2) Care in corridors and other non clinical spaces has been normalized, which in the opinion of the consultant who gave evidence is unsafe. (3) When conducted routinely, care in corridors and other non clinical spaces reduces the capacity of the Emergency Department so that should acuity escalate, it is likely to cause delays to the release of ambulances. (4) The underling obstacle to improving flow through the hospital and relieving pressure on the Emergency Department is the significant number of patients who are medically fit to be discharged but whose discharge is delayed due to non medical reasons.
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 14th March 2025. 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 following who may find it useful or of interest. The Welsh Government, the Chief Executive of the Welsh Ambulance Services NHS Trust, the Chief Executive of the Cardiff and Vale University Health Board; The family; The General Practitioners who were recognised as interested persons 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	**17th January 2025** **SIGNED**  **D Regan** **Assistant Coroner**