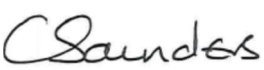
Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: <u>The Minister for Health (Wales)</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 14/3/2024, an investigation was opened touching upon the death of Jeffrey Martin Tyler The investigation concluded at the end of the inquest on 12/2/2025 <u>The conclusion of the inquest was recorded as</u> Death by Natural Causes <u>The medical cause of death was:</u> 1a) Cardiomegaly 2) Chronic Kidney Disease
4	**CIRCUMSTANCES OF THE DEATH** On 19/2/2024, Jeffrey Martin Tyler called the emergency services at 19:30. He indicated that he was alone in his home, that he was having chest pains and having difficulty breathing. He remained on the call to the ambulance service during which time his condition worsened, his breathing deteriorated, and he started vomiting. The call was ended at 2010 hours. An ambulance arrived at 0017 hours on 20/2/24. By the time the crew attended, Mr Tyler could not be revived, and his death was confirmed by paramedics at 0110 hours on 20/2/2024.

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - In evidence I found that the call handlers had been following the correct algorithm as dictated by the nationally adopted Medical Priority Dispatch System (MPDS), and that he was appropriately categorised as requiring an Amber 1 ambulance. However, it would also have been clear to any clinician that he was deteriorating and was in the process of having a cardiac event. Mr Tyler was on his own and could not inform the ambulance service if his condition deteriorated. Despite Mr Tyler being alone and being in extremis, the MPDS Code was maintained at Amber 1. The waiting time was between 5 and 7 hours.
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. I am informed that only those callers who are unconscious and clearly in the throes of dying are afforded a Red Ambulance. This limited categorisation puts at risk patients who are severely unwell and are also close to being in an unrecoverable condition. I am informed that the MPDS categorisation has been adopted by Welsh government, and I bring to your attention the flaws in the process.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 15 April 2025, 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 Jeffrey Martin Tyler • Welsh Ambulance Service 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 18/2/2025** Signed  Caroline Saunders **His Majesty's Senior Coroner for Gwent.**