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:** **1. Welsh Ambulance Service NHS Trust** **2. Department of Health** **3.**
1	**CORONER** I am Louise Hunt senior coroner for the coroner area of Powys Bridgend and Glamorgan Valleys
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 30th May 2013 I commenced an investigation into the death of Winston Llewellyn Johns. The investigation concluded at the end of the inquest on 24 October 2013. The conclusion of the inquest was Mr Johns died from injuries sustained as a result of advised CPR during a 999 call on the 22nd May 2013. The low blood sugar of 1.4 reported during the 999 call was not factored into the decision making.
4	**CIRCUMSTANCES OF THE DEATH** Mr Johns was a know diabetic. His son visited him and found him unrousable. He checked his blood sugar which was 1.4 (low). He called 999 and explained his father was diabetic and had a low blood sugar. His father was snoring. He was initially advised to maintain the airway in the chair his father was sitting in. The son described the breathing as normal. The son was then advised to put his father on the floor and commence CPR. He did as advised. During CPR Mr Johns sustained a sternum fracture and multiple rib fractures. The paramedics arrived and gave a glucose drip to restore the blood sugar to 6.8. Mr Johns was admitted to hospital where he later died from pneumonia caused by the rib and sternum fractures
5	**CORONER'S CONCERNS** 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. – (1) Mr Johns son clearly confirmed the low blood sugar at the beginning of the call. This critical important information was not factored into the advice provided to him by the operator. (2) The computer programme used by the ambulance service does not take into account critical clinical information as a result the operator incorrectly advised CPR despite the risks that entails.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 25th December 2013. 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 Mr John's junior. I have also sent it to the Department of Health who may find it useful or of interest. 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	**[DATE]** 30/10/13 **[SIGNED BY CORONER]**