REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Welsh Ambulance Services NHS Trust, HM Stanley Site, St Asaph, Denbighshire LL17 0RS, BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and 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** On the 28th of March 2014 I commenced an investigation into the death of Clive Harold Turner (DOB 12.11.40, DOD 26.03.2014). The investigation concluded at the end of the inquest on the 4th of September and I recorded an narrative conclusion in respect of the death in the following terms :- At around 16.00 hours on the 25th March 2014 a call was made from the home of Clive Harold Turner to the Welsh Ambulance Service NHS Trust requiring medical assistance for him. Due to the lack of available resources a First Responder did not attend until 1 hour and 27 minutes after the initial call. The First Responder assessed Mr Turner as requiring admission to hospital and requested assistance. No ambulances became available to provide this assistance until 21.30 hours, this being 5 hours 30 minutes after the initial 999 call and more than an hour after the First Responder had advised control that Mr Turner was at the limit with the amount of morphine given. The ambulance arrived at the Maelor Hospital Wrexham at 21.53 hours, however there was a further 2 hour delay in his handover to nursing staff at 23.44, 8 hours and 45 minutes after the original 999 call. Following examination at the emergency department he was incorrectly diagnosed as being constipated and was discharged in the early hours of the 26th of March 2014 arriving home at 03.00 hours. He subsequently was verified as life extinct at his home at 13.24 on that same date as a result of a Gastro Intestinal Haemorrhage due to Ischaemic Bowel as a result of Atherosclerosis.

4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are as set out in the narrative conclusion appearing in paragraph 3 hereof.
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. That there were significant delays in the provision of assistance to Mr Turner by the Welsh Ambulance Service 2. That the current practices in place for the handover of patients at an Emergency Department far too often results in wholly unacceptable delays with patients being kept waiting for long periods in ambulances and ambulance resources consequently being unavailable for allocation to other calls. Whilst this is a multi-factorial problem, improvements must be made so as to reduce the risk of future deaths. 3. It is of considerable concern to me that item 2 above is a direct repeat of a concern which I raised in a previous Regulation 28 report following the death of Mr Frederick Pring in March 2013, twelve months before that of Mr Turner, the joint response of WAST and BCUHB being received exactly one week before Mr Turner's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 7th November 2014 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 Person – [redacted] (Son of the deceased) [redacted] (partner of the Deceased) 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]12th September 2014 [SIGNED BY CORONER]**