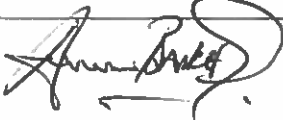


## ANNEX A

### REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. <b>The Medical Director/Chief Executive Welsh Ambulance Trust</b></li><li>2. <b>Chief Coroner</b></li><li>3. <b>[REDACTED]</b></li></ol>
1	<p><b>CORONER</b></p> <p>I am Andrew Roger Barkley, Senior Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>I commenced an investigation on the 25<sup>th</sup> August 2015 into the death of Christopher George Connor. Investigation concluded at the end of the inquest on 12<sup>th</sup> November 2015, the conclusion was "Accidental Death" and the medical cause of death was 1a. Head Injury.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>The deceased had been socialising at a public house on the evening of Saturday 15<sup>th</sup> August 2015 with his wife and her relatives. He left in the early hours, believed to be about 1am to return home and is then found shortly after 1:15am collapsed and unresponsive on a pavement not far from his home address. An ambulance is called by a passerby and takes over 1 hour and 15 minutes to arrive on scene.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"><li>(1) The delay in the attendance of an ambulance which, on the evidence, only arrived after police officers arrived on the scene and "expedited" the call to the ambulance control room.</li></ol>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>

7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 7<sup>th</sup> January 2016. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to [REDACTED] who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>12<sup>th</sup> November 2015</b>      <b>SIGNED:</b> </p>