**ANNEX A**

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

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. Welsh Ambulance Service Trust<br>2. Minister for Health, National Assembly for Wales<br>3. Chief Executive, Cardiff and Vale University Health Board |
| 1 | **CORONER**<br><br>I am Rachel Knight, Assistant Coroner for the coroner area of South Wales Central. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 25th April 2018 an inquest was opened in to the death of Mr Richard Thomas Peter Barrett. The investigation concluded at the end of the inquest on 26th July 2018. The conclusion of the inquest was narrative and read as follows: "Richard Barrett died as a consequence of the combined toxic effect of both prescribed and over-the-counter medication taken together with alcohol, in circumstances in which his intention was unclear. There was a delay of 4 hours in sending any emergency response." |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 20th April 2018, Mr Barrett took an overdose of 20 diazepam tablets, 20 zopiclone tablets and 20 Sleep Ease tablets, with a large quantity of alcohol. About 40 minutes after having taken the drugs, at 02:29 Mr Barrett rang 999 and asked for an ambulance. He was extremely drowsy and slightly incoherent during the 999 call, in which he gave a truthful account of the drugs he had taken, which he described as a 'massive overdose'. His 999 call was a cry for help.<br><br>He was told that there was a high demand on the service at that time, and ambulances would be prioritised for sicker patients first, such as those in cardiac arrest or choking. He was told an ambulance would be with him as soon as possible. Staff at the Call Centre attempted to ring Mr Barrett to conduct a welfare check at 05:13. There was no |

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| | answer. Nothing was done to re-categorise the priority of the call. An ambulance was ultimately dispatched at 06:18 and by the time the paramedics got inside his flat at 06:50, Mr Barrett had already died. Police were not involved until 06:39. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest, and the investigation leading up to it, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>[BRIEF SUMMARY OF MATTERS OF CONCERN]<br><br>(1) 'Demand analysis' seriously underestimated the number of ambulances required in Cardiff and the Vale that night.<br><br>Evidence showed that only 7 ambulances were available up until 2am, then 5 available up until 3am. Also 7 hours of ambulance time was lost during the period 02:26 – 06:30 due to delays at A&E.<br><br>(2) There does not seem to be a reliable system for the making and chasing-up of 'welfare calls'.<br><br>Evidence showed that it was not until 2 hours 45 minutes after the initial call that an attempt was made to ring the patient back. It was known that the patient had taken a massive overdose of sleeping tablets at 01:50. It was not enquired by the call handler as to whether he had also taken alcohol, or whether he was alone. When there was no response from his telephone at 05:13 there was a missed opportunity to re-categorise the incident.<br><br>(3) The target turnaround time for ambulances at A&E is wildly unrealistic.<br><br>Evidence showed that both the University Hospital of Wales and Llandough Hospital were averaging 3 times the target of 15 minutes that night with the longest turnaround being over 100 minutes. Such delay must have a knock-on effect upon the 'demand analysis'.<br><br>(4) The police could have been asked to perform a welfare check.<br><br>Evidence showed that the Ambulance Trust is pessimistic in assuming that the police are also under-resourced and would not be able to assist in such a task. Here the police were not even asked if they could help. Had he been found earlier, whether by police or ambulance, there is a chance that the deceased may have been able to be given first aid and had a better chance of survival. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you and |

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| | your organisation have the power to take such action. You may wish to consider the following points:<br>(a) Demand analysis and its fitness for purpose<br>(b) Provision of adequate ambulance and call handler resources in a growing city<br>(c) The process of making, and timing of welfare calls, particularly in overdose cases<br>(d) Turnaround delays at the major hospitals and the unrealistic target<br>(e) Asking the police to undertake a welfare check in an overdose case, where the patient is alone and an ambulance is likely to be hours away |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th September 2018. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the:<br><br>1. Chief Coroner<br>2. Welsh Ambulance Service Trust<br>3. Minister for Health, National Assembly for Wales<br>4. Chief Executive, Cardiff and Vale University Health Board<br>5. Chief Constable for South Wales Police<br>6. The family<br><br>who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br>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 | **30th July 2018** **SIGNED:**  <br><br>**Miss Rachel Knight**<br>**Assistant Coroner** |