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. **Mr J Killens Chief Executive Welsh Ambulance Services NHS Trust Regional Ambulance Headquarters Vantage Point House Ty Coch Way Cwmbran NP44 7HF** 2. **Ms Judith Paget Chief Executive Aneurin Bevan University Health Board St Cadoc's Hospital Lodge Road Caerleon NP18 3XQ**
1	CORONER I am Wendy Ann James, Acting Senior Coroner, for the coroner 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 19/01/18 I commenced an investigation into the death of Diane Greenslade (dob 04/08/1946). The investigation concluded at the end of the inquest on 29/11/18. The conclusion of the inquest was that Diane Greenslade died as a result of natural causes following a delay in medical intervention due to a fifteen and a half hour delay in the Ambulance Service responding to the emergency call. The medical cause of death being: 1 (a) Cerebral infarction (b) Intracranial vessel atheroma 2. Delay in medical intervention
4	**CIRCUMSTANCES OF THE DEATH** At 22.33 on 05/01/18, after hearing moaning coming from Mrs Greenslade's flat, her neighbour activated her Careline alarm to alert staff of her concerns. After failing to make contact with Mrs Greenslade or her family, at 22.39 the staff telephoned 999 and requested an ambulance to attend at Mrs Greenslade's property. The case was categorised as a Green 3 call. Family attended at her home shortly after 11.00 on 06/01/18 to find Mrs Greenslade moaning, lying on the bedroom floor with a chest of drawers on top of her. At 11.46 her daughter telephoned 999 and requested an ambulance. The call was categorised as an Amber 1 call. At 12.23 she telephoned again and made a further call at 13.31. A rapid response vehicle arrived at 14.05 and an ambulance at 14.38. The rapid response vehicle had been based approximately 8 minutes away from Mrs Greenslade's home since at least 06.30 and had not responded to any calls as it was ring fenced for red and amber 1 calls. Mrs Greenslade told the paramedic she thought she had had a stroke. She was moved to the rear of the ambulance and suffered a cardiac arrest and died.
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 could 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) The initial call was categorised Green 3 without any contact being made with Mrs Greenslade or her family and without any clinical assessment. (2) After failing to make contact, no consideration was given to either upgrading the call category or to contacting the Police to ask them to carry out a welfare check. (3) Demand for ambulances was high compounded by excessive delays at hospitals. (4) A rapid response vehicle had been based only eight minutes away from Mrs Greenslade's home since at least 6.30 and had not responded to any calls as it was ring fenced for red and amber 1 calls. (5) The delay in medical intervention must have played a significant role in Mrs Greenslade's death.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th February 2019. 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: 1. The family I have also sent it to the Minister for Health and Social Services 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	**21st December 2018** W A James. **Acting Senior Coroner (Gwent)**