ANNEX A

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:** **The Chief Executive of the Welsh Ambulance Service**
1	**CORONER** I am David Regan, Assistant Coroner, for the coroner area of South Wales 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** A Coronial investigation was commenced into the death of Ffion Louise Jones concluding at the end of the inquest which I conducted on 12th and 13th September 2019. The conclusion was a narrative conclusion and the medical cause of death was 1a. hypoxic ischaemic brain injury; 1(b) out of hospital cardiac arrest; 1(c) addisonian crisis
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Ffion Jones died as a result of a crisis of Addison's disease following a collapse at the surgery of her General Practitioner. Despite requests for urgent attendance, there was no ambulance attendance for almost 1 hour following her

General Practitioner's emergency call. The call was not escalated to the clinical support desk as it should have been. Escalation would have been likely to have led to ambulance attendance prior to Ffion arresting, in which case Ffion would have been resuscitated and quickly transferred to hospital. It is likely that she would have survived.

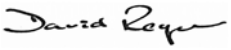
The narrative conclusion which I returned was:

Ffion Jones died as a result of an Addisonian Crisis She suffered a seriously damaging arrest at her General Practitioner's surgery while waiting almost one hour for ambulance service assistance that had been requested urgently, but had been delayed by a failure to escalate her case to the clinical support desk.

The Inquest focused upon:-

a. The fact that Ffion presented to her GP shortly after 14.00 on 7.12.16 in a severely unwell state such that her GP quickly decided that she needed urgent transfer by ambulance to hospital
b. The GP initially sought to effect this using a number which the ambulance service had informed her could allow health care professionals to obtain an emergency response
c. The GP then telephoned 999 as directed and sought to stress the urgency of the requirement for ambulance attendance.
d. The call was subject to standard questioning and the response assessed by the MPDS prioritisation tool and graded amber 2
e. Her call was not referred to the clinical support desk as it should have been
f. Had this occurred the response would have been upgraded from amber 2 to amber 1
g. The clinical support desk operates a referral system which includes supporting members of the public and operates a queuing system
h. There remains no dedicated means for an external health care professional to have urgent access to a discussion with a clinical member of staff to ensure that their assessment of their patient's clinical need is fully, properly and quickly conveyed to the ambulance service, to ensure the proper assessment of the urgency of the response.

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) The Improvement plan provided at the Inquest did not include any consideration of the specific shortcomings in service provision leading to Ffion's death and the witness speaking to it was unable to address these issues (2) There remains no dedicated means for an external health care professional to have urgent access to a discussion with a clinical member of ambulance service staff to ensure that their assessment of their patient's clinical need is fully, properly and quickly conveyed to the ambulance service, and thus that there is a properly informed assessment of the urgency of the response. (3) There is a real risk of the recurrence of the circumstances leading to Ffion'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 11th November 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 family who may find it useful or of interest, Heath inspectorate Wales, Welsh Government, Medical Director of Cardiff and Vale University Health Board. 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	**16th September 2019** **SIGNED:**  **D Regan** **Assistant Coroner**