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:** 1. Welsh Ambulance Services NHS Trust
1	**CORONER** I am Graeme Hughes, Acting Senior 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** On the 19th October 2018 an inquest was opened in to the death of Mr Paul Mclean. The investigation concluded at the end of the inquest on 18th October 2019. The conclusion of the inquest was a Narrative: "Our conclusion as to the death of Mr Paul Mclean, was due to misadventure. It's probable that taking synthetic cannabinoids led to status epilepticus which then further led to deterioration in health at Princess of Wales Hospital. On a balance of probabilities, to which the miss-categorisation of the call to emergency services at 22:18am on 22nd July 2018, contributed to the delay in commencement of paramedic intervention/treatment. We believe that the delay contributed to prolonged status epilepticus. We believe that the prolonged stay in hospital prolonged agitation and development of pneumonia and sepsis in October 2018 and his death on 9th October 2018 was contributed to by his prolonged status epilepticus on 22nd July 2018".
4	**CIRCUMSTANCES OF THE DEATH** I attach a copy of the record of the record of inquest setting out the circumstances of Mr McLean's death as recorded by the jury. Whilst the inquest initially focused on a number of wider issues relating to the death of Mr McLean, what became the issue at its core, was the appropriateness of the categorisation of the initial call to the Welsh Ambulance Service (WAST) at around 10:18 on the 22nd of July 2018.

	In particular, the series of questions posed by the call handler, and the responses thereto, which led to the initial code red *colouring* being *downgraded* to an amber one categorisation. This meant that an anticipated 15-20 minute emergency response (due to the location of the available crew to the incident scene), became around 80 minutes. The jury found that that extended response time, contributed to prolonged *status epilepticus*, and his subsequent death.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows. – 1. The adequacy/accuracy of the scripting of questions for *seizure/fitting* calls. In particular, and in relation to code 12D02 calls (post 19.6.19) the requirement for a healthcare professional to call back after 20 minutes of continuous fitting to *trigger* a call upgrade from Amber 1 to Red. In an email from [redacted] of 17.10.19 @ 07.11 and read to the court, it was confirmed that the question is not currently asked of the caller to WAST, *how long has the patient been fitting?* This would appear to be a crucial piece of information in order to ascertain as accurately as possible, the known timing of the onset of the fit, for the purposes of determining when the 20minutes has elapsed. E.g. If it is known that the patient has already been fitting for 10 minutes, then the advice to call back should be in 10 minutes hence. If the fit has just commenced, then obviously, that advice can be for a 20 minute call back. 2. The wider issue of whether a response from a healthcare professional (to a question(s) posed by a call handler) that the patient is *not maintaining his/her airways* should in itself trigger/categorise a continuous red code. The evidence of [redacted] at the Inquest, was that such a scenario was of the highest clinical priority, as the patient had a high risk of cardiac arrest in such circumstances. There appeared some tension in the evidence surrounding the 12D01/02/03 categorisation as to which code would be triggered on the volunteering, or otherwise of this indication from the caller. 3. Whether a pathway exists, or should be created for updating G4S – the operators of Parc Prison with changes implemented by the WAST affecting call prioritisation. This is likely to have the benefit of ensuring that healthcare professionals at the prison are fully aware of what is expected of them in an emergency call to WAST and what response can be expected from WAST at the time an emergency call is placed. 4. Whether there is, or should exist, a clear pathway for dialogue between the Princess of Wales Hospital Emergency Department clinicians and WAST in

	relation to best practice for call categorisation. In particular, whether there should be regular input from the emergency department consultants at the Princess of Wales Hospital into the CPAS group for the purposes of assisting in relation to the appropriate categorisation of calls.
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 19th December 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, Family, Welsh Government, Medical Director Cwm Taf Morgannwg Health Board, G4S 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	**22nd October 2019** **SIGNED:** **Mr Graeme Hughes** **Acting Senior Coroner**