REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Chief Executive Welsh Ambulance Services NHS Trust ("WAST") mailto:** [redacted] 2. [redacted] **Minister for Health mailto:Correspondence.** [redacted]
1	**CORONER** I am Colin Phillips, acting senior coroner, for the coroner area of Swansea and Neath Port Talbot
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 15th August 2019 I commenced an investigation into the death of Andres Roberts aged 47 years. The investigation concluded at the end of the inquest on 22nd September 2020. The conclusion of the inquest was a Narrative Conclusion that he died on the 12th August 2019 at Morriston Hospital Morriston Swansea as a consequence of thrombolysis administered to treat a large stroke. Thrombolysis was administered in accordance with local and national guidelines. Mr Roberts suffered a large intracranial bleed which is a known complication of thrombolysis treatment. It is not possible to say whether a faster response by Welsh Ambulance services NHS Trust would have affected the outcome as each patient reacts differently to the treatment. and the medical cause of death was 1a Right cerebral Haemorrhage following Thrombolysis (11/08/2019) 11 Hypertension.
4	**CIRCUMSTANCES OF THE DEATH** (1) There were 4 emergency 999 calls made on behalf of patient in relation to a suspected stroke. The calls were graded as Amber 1. The incident was reported at 01:38 and ambulance arrived at 04:05. The response time was 2 hours and 20 minutes. This was due to lack of resources and high demand. (2) 04:31 patient arrives at Morriston Hospital as a pre-alerted stroke thrombolysis call and at 05:16 care handed over to hospital staff (3) Thrombolysis treatment administered at 05:25 (4) A peri-arrest call made at 08:30 patient suffering a seizure. CT scan of head revealed a large bleed in area affected by ischaemic stroke. Patient not suitable for neurological intervention and he passed away at 22:45
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) In an acute stroke 'time is brain' which means that the sooner thrombolysis (clot busting drug) is administered the better are the chances of recovery and subsequent survival. The deceased was thrombolysed with 4.5 hours of stroke onset, however, based on research and clinical data if the patient was to arrive in A&E sooner then he would have received the above mentioned treatment earlier which may have affected the outcome. Unfortunately, the stroke consultant was unable to comment on the exact likelihood of a different outcome as " he did have a big stroke to begin with and each patient reacts differently to the treatment" (2) My concerns centre on :- A) the appropriateness of the grading of stroke patients falling in the amber category and B) whether a specific time target should be set and C) whether additional resources should be made available to WAST to meet these targets
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 18th November 2020. 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 [redacted] 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	**23 September 2020**  **[SIGNED BY CORONER]**