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. [redacted] **Medical Director at Cardiff & Vale Health Board** 2. [redacted] **Medical Director at ABMU Health Board** 3. [redacted] **Medical Director at Cwm Taff Health Board** 4. **Chief Coroner** 5. [redacted] **(NOK)** 6. **Welsh Health Specialised Services Committee** 7. **Rebecca Evans, Minister for Health & Social Services**
1	**CORONER** I am Graeme Hughes, 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** On the 20th April 2016 I commenced an investigation into the death of Dr Imad Hassan. The investigation concluded at the end of an inquest on the 16th August 2016. The conclusion of the inquest was that: "On the 17th April 2016 the deceased suffered an out of hospital cardiac arrest following a heart attack. He was resuscitated and diagnosed with having sustained an ST Myocardial Infarction. Remaining clinically unstable he was taken to the nearest hospital, Prince Charles, Merthyr Tydfil. Treatment partially stabilized his condition to the extent that transfer to another hospital for a *rescue* PCI Intervention procedure was not clinically indicated. Even if a rescue PCI Intervention procedure had been indicated, there was no critical care capacity (at the time) to undertake this, at UHW Hospital, Cardiff or Morriston Hospital, Swansea".
4	**CIRCUMSTANCES OF THE DEATH** On the evening of the 17th April 2016 Dr Hassan suffered an (out of hospital) heart attack and went into cardiac arrest. He was resuscitated by the emergency services at the scene and taken to Prince Charles Hospital for urgent medical attention. His condition was partially stabilised and there were discussions between the clinicians at Prince Charles Hospital, University Hospital of Wales in Cardiff and Morriston Hospital in Swansea as to Dr Hassan's suitability for Percutaneous Coronary Intervention (PCI) to be performed as at either Morriston Hospital or UHW in Cardiff. Dr Hassan suffered a further Cardiac Arrest at Prince Charles Hospital and died 04:35hrs on the 18th April 2016.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concerns. 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. –

	[BRIEF SUMMARY OF MATTERS OF CONCERN] 1) In the event that a patient at Prince Charles Hospital is deemed suitable for PCI there is currently no formal *back up* plan in place, to enable the PCI to proceed, should UHW in Cardiff or Morriston Hospital in Swansea be unable to accept that patient. 2) In such circumstances, a patient meeting the criteria for PCI is unable to undergo that procedure, increasing the risk of his/her death, until there is such capacity for that patient to be admitted to UHW or Morriston Hospitals for PCI. 3) As per the evidence of [redacted] given at inquest, an agreed short term pathway needs to be put in place to access adult critical care beds outside Wales and a bed management pathway put in place. 4) There is currently no agreed pathway for an unconscious STEMI patient requiring PCI in tertiary services as there is currently for conscious patients with STEMI. Although in the case of Dr Hassan transfer to another hospital for a *rescue* PCI was not clinically indicated, that may not necessarily be the case in the future, particularly, in a patient who has had a short period of unconsciousness and a PCI is clinically indicated. 5) In similar circumstances as pertained on the evening prior to / the morning of Dr Hassan's death such a patient (as described in 4)) maybe deprived the opportunity of undergoing rescue PCI due to lack of capacity at either UHW in Cardiff or Morriston in Swansea.
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. In particular, formulating and implementing a formal *backup plan* in the event that both UHW and Morriston Hospitals are unable to accept a patient for PCI and by the creation and implementation of an agreed pathway for the unconscious STEMI patient requiring PCI in tertiary services.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st November 2016. 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, Cardiff & Vale Medical Director, ABMU Medical Director, Cwm Taff Medical Director, Welsh Health Specialised Services Committee, Minister for Health & Social Services and the family 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	**5th September 2016** **SIGNED:** **Graeme Hughes** **HM Assistant Coroner**