REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and 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 24th of December 2014 I commenced an investigation into the death of Lynn Morris (DOB 11.6.47, DOD 20.12.14). The investigation concluded at the end of the inquest on the 17th of December 2015. The cause of death was 1(a) Lobar Pneumonia and I recorded a Conclusion of Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that on the 19th of December 2014 the Deceased was admitted to the Maelor Hospital Wrexham suffering from sepsis. After being initially assessed and treated within the Emergency Department it was deemed necessary to escalate her care to the Critical Care Unit for renal filtration, however there was then a delay in the transfer of her care as there were no critical care beds available despite patients on critical care being fit for discharge to ward as a result of the medical and surgical wards being full to capacity. As a consequence there was a delay in the commencement of appropriate treatment and the patient died in the early hours of the following morning.
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 :- Despite ongoing work by the Health Board in seeking to improve the flow of patients through hospital by ensuring their timely discharge, the problem of Delayed Transfers of Care (DeTOC) remains as great a problem at this time as it was in December 2014. The ongoing problems associated with the throughput of patients and DeTOC means the patients are being placed at risk and could result in avoidable deaths.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 15th February 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 and to the following Interested Person – [redacted] (Son of the Deceased) and Mr J. Bowling (Partner of the Deceased) 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	**[DATE] 21st December 2015** **[SIGNED BY CORONER]**