REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Welsh Ambulance Services NHS Trust, HM Stanley Site, St Asaph, Denbighshire LL17 0RS, 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 13th of November 2014 I commenced an investigation into the death of Pamela June Conway (DOB 13.6.43, DOD 8.11.14). The investigation concluded at the end of the inquest on the 23rd of August 2016 and I recorded a conclusion that the death was due to natural causes which were exacerbated by delayed medical treatment.
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that for multifactorial reasons there was a delay of around 21 hours before the deceased received antibiotics for an infected knee and that during the course of this period she went into irrecoverable septic shock. Amongst the reasons for the above delay was the length of time it took for Mrs Conway to be discharged from the ambulance to the hospital on the 10th of October 2014. On this date the emergency department at Wrexham Maelor Hospital was extremely busy and despite an agreed handover time of 15 mins, Mrs Conway waited in the ambulance for 2 hours and 50 mins. The longest waiting time on that date for a patient handover was one minute short of five hours. Whilst this delay alone did not result in her death, it did form a part of the cumulative delays by which Mrs Conway was denied the best chance of having her knee infection successfully treated and hence not going on to develop sepsis.
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. That notwithstanding changes which have been made by both BCuHB and WAST, there remain wholly unacceptable delays with patients being kept waiting for long periods in ambulances and ambulance resources consequently being unavailable for allocation to other calls as a result of which the risk of future deaths continues. 2. Evidence at the inquest indicated that the problem of "patient flow" within the Maelor Hospital continues to result in delays within the Emergency Department and it is of considerable concern to me that such problems have been the subject of previous regulation 28 reports and are also within the scope of a number of ongoing inquests.
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 21st October 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] (Daughters 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	**26th August 2016 [SIGNED BY CORONER]**