John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW, Welsh Ambulance Services NHS Trust, HM Stanley Site, St Asaph, Denbighshire LL17 0RS,
1	**CORONER** I am John Adrian Gittins, Senior Coroner for 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 the25th of April 2018 I commenced an investigation into the death of Gladys May Williams (DOB 11.1.25 DOD 24.4. The investigation concluded at the end of the inquest on the 6th of September 2018. The conclusion of the inquest was one of an accidental death the Cause of Death being recorded as 1(a) Aspiration Pneumonia 2. Frailty with Fracture of Cervical Spine
4	**CIRCUMSTANCES OF THE DEATH** On the 6th of March 2018 the Deceased fell at her care home and was taken to the Wrexham Maelor Hospital where she was examined and subsequently discharged the same day. She continued to be unwell and an ambulance was called again at 21.21 following examination by the Out of Hours doctor. Due to her continuing deterioration a further call was made to the ambulance service at 04.01 on the 7th of March however no ambulances were available and an ambulance did not arrive until 07.10. Thereafter the ambulance left the scene at 07.41arriving at the Emergency Department of the Maelor Hospital, Wrexham at 07.55. Due to the department being busy her care was not handed over to hospital staff until 09.27 more than twelve hours after the original call from her care home which is less than fifteen minutes' drive from the hospital although it cannot be said that this delay contributed to her death.
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. – The issues of ambulance delays/admission to ED/availability of resources/patient flow and the multifactorial problems associated with cases of this nature have been reported upon by me on numerous occasions following previous inquests. Despite the above reports issued to the Health Board and Ambulance Service these problems appear to be continuing notwithstanding the various measures which I am informed have been and are continuing to be put in place by WAST and BCUHB to mitigate such problems

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	and I continue to believe and be extremely concerned that patients' lives are being placed at risk as a result. Whilst it no longer appears to be the case that problems of this nature can be attributed to "winter pressures" it is nonetheless of grave concern that we are approaching another winter period without any clear indication that progress is being made to improve upon the previous position.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 5th of November 2018 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 Family of the Deceased and to the Chief Coroner. 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	Dated 10th September 2018 Signature  Senior Coroner for North Wales (East and Central)

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