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
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 the 26th of February 2018 I commenced an investigation into the death of Peter Andrew Connelly (DOB 17.8.47 DOD 20.2.2018) The investigation concluded at the end of the inquest on 31st of October 2019. The conclusion of the inquest was one of a death arising from Natural Causes the Cause of Death being recorded as 1(a) Multi Organ Failure (b) Acute Pancreatitis 2. Gall Stones
4	**CIRCUMSTANCES OF THE DEATH** On the 19th of February 2018 the Deceased was transferred by ambulance from his home in Fairbourne, Gwynedd to the Maelor Hospital, Wrexham arriving at 14.15 hours. At this time the Emergency Department was experiencing extreme pressures and there were a number of ambulances already waiting outside. Mr Connelly was briefly triaged in the rear of the ambulance after about an hour and was categorised Orange (to be seen by a doctor within 15 minutes). At around 19.45 his condition began to deteriorate but he was not brought into ED until 22.00 and was not seen by a doctor until 23.00 having therefore waited 7 hours, 45 minutes for admission and 8 hours 45 minutes to be medically examined. He was diagnosed as having acute pancreatitis resulting in his condition continuing to deteriorate rapidly and he died on the 20th of February 2018 at 16.45. (It is accepted that the delay in being treated did not cause or contribute to Mr Connelly's 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. – In February 2019 I issued a regulation 28 report to BCUHB in which I expressed the following concerns :

Coroner's Office, County Hall, Wynnstay Road, Ruthin, LL15 1YN
Tel 01824 708047 | Fax 01824 708048

	"Following an inquest which concluded in January 2014 I issued a regulation 28 report in which I expressed concerns regarding the handover of patients at an emergency department which resulted in "unacceptable delays with patients being kept waiting for long periods in ambulances and ambulance resources consequently being unavailable for allocation to other calls". In the intervening period from then until the present either I or my Assistant Coroners have issued at least twelve similar regulation 28 reports expressing concerns associated with unacceptable delays and yet despite being given assurances in the responses to the same by BCUHB and WAST (and other organisations) that action is being taken to reduce such delays, the situation continues to prevail. As has been stated previously in my other reports, I recognise that the issues which cause these difficulties is multifactorial, however unless services and resources are made available or working practices altered to facilitate change then it is inevitable that future deaths will occur which might have otherwise been preventable. Patients' lives are being placed at risk and this is wholly unacceptable." Notwithstanding the fact that Mr Connelly's death preceded the said February 2019 report and that there has been a reduction in the number of hours which ambulances were kept waiting outside ED since his death, the evidence which I heard at his inquest informed me that the ED at the Maelor Hospital, Wrexham continues to operate under extreme pressures and at an average scale of escalation (namely 3.1) which I consider is a clear indication that the various factors which cause delays in admission to hospital, have not been eliminated. Consequently it remains the case that delays in treatment may occur along with deaths which should be preventable by timely medical intervention.
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 2nd January 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 Family 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	Dated 7th November 2019 Signature Senior Coroner for North Wales (East and Central)

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