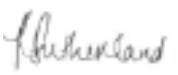
ANNEX A

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:** **Welsh Ambulance Service Trust** **Betsi Cadwaladr University Local Health Board**
1	**CORONER** I am Kate Sutherland, Acting Senior Coroner for North West Wales
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 26 August 2021, an investigation was commenced into the death of Glenys Roberts. The investigation concluded at the end of an Article 2 compliant Inquest on 18 October 2022. A narrative conclusion was given:- At around 5pm on 23 August 2021 Glenys Roberts was found by a passer-by on the floor by her front door. Glenys Roberts was complaining of pain and loss of sensation in her legs. She was conveyed to Ysbyty Gwynedd and arrived at 19.46. Assessment in the Emergency Department of Ysbyty Gwynedd led to a diagnosis of saddle embolus of the aortic bifurcation. With vascular across the Health Board centralized at Ysbyty Glan Clwyd, some 30 miles away, the Consultant at Ysbyty Gwynedd discussed Glenys Robert's case with the vascular consultant on call based at Ysbyty Glan Clwyd at 21.19 hours who advised 5000 unit bolus dose of intravenous heparin and CT angiogram ad emergency ambulance transfer to Ysbyty Glan Clwyd. The CT angiogram revealed a complete occlusion of the distal aorta. Arrangements were made for Glenys Roberts to be admitted directly onto a ward at Ysbyty Glan Clwyd rather than being admitted via the Emergency Department to prevent delays whilst being admitted. There was, however, a failure to convey Glenys Roberts by ambulance from Ysbyty Gwynedd to Ysbyty Glan Clwyd in a timely manner or at all for vascular surgery. Glenys Roberts continued to deteriorate and became too frail to be conveyed to Ysbyty Glan Clwyd when an ambulance became available to 05:15. Glenys Roberts was certified deceased in Ysbyty Gwynedd at 07.39 on 24 August 2021. There was a missed opportunity for Glenys Roberts to undergo vascular surgery by not being conveyed to Ysbyty Glan Clwyd thereby failing to optimize an opportunity for life saving surgery but it cannot be said that this would have altered the outcome for her.

4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- See narrative conclusion for findings
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. –
	There were no available ambulance resources to convey Glenys Roberts from Ysbyty Gwynedd to Ysbyty Glan Clwyd. The reason for this being multifactorial but particularly due to fit patients remaining in hospital due to no community care available to them, thereby remaining in hospital and limiting patient beds. Whilst action is being taken by WAST and BCUHB the following concerns remain:- 1. Review of and action relating to intra hospital transfers has been too slow 2. Review of the current vascular pathway to ensure vascular emergency transfers have direct admission into hospital is still not fully operational and has been too slow 3. Development of a pan Betsi Cadwaladr University Local Health Board ambulance handover plan to support reducing lost hours to improve performance and availability is still not in force and has been too slow
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 12 December 2022 Only, 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 also sent a copy of my report to Glenys Roberts' family and [redacted], Minister for Health and Social Services 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	24 October 2022 **SIGNED:**  Kate Sutherland, Acting Senior Coroner for North West Wales