Kate Sutherland
Assistant Coroner for North Wales (East and Central)

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*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 NHS Trust** **Betsi Cadwaladr University Local Health Board**
1	**CORONER** I am Kate Sutherland, Assistant Coroner, for North Wales (East & 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 24 March 2022, an investigation was commenced into the death of David Colin Strachan. The investigation concluded at the end of an Inquest on 14 February 2023. The conclusion of the inquest was a narrative conclusion. The cause of death was recorded as:- 1a. Acute myocardial infarction 1b. Coronary artery atheroma

4	**CIRCUMSTANCES OF THE DEATH** David Strachan was aged 76 years when he died on 16th March 2022 at his home address in Llangollen, Denbighshire. At 23.20 hours on 15 March 2022, he experienced a sudden onset of chest pain, vomiting and became clammy with shortness of breath. A number of 999 calls were made to the Welsh Ambulance Service but it was not until 9.10am, some 9 hours and 52 hours from the initial call that an ambulance and paramedics arrived. An ECG by paramedics indicated that Mr Strachan had suffered an ST elevation myocardial infarction. He was conveyed directly to the North Wales Cardiac Centre at Ysbyty Glan Clwyd and following investigations he was transferred to the Coronary Care Unit. On arrival his breathing weakened and he died at 12.27pm on 16 March 2022 in hospital.
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 causes of the ambulance delay were that all available resources were managing incidents of a higher acuity or the same category but registered prior and there were significant handover delays across all BCUHB sites. The matters of concern herein are longstanding and multifactorial and despite proposed future action significant concerns remain. The Welsh Ambulance Service NHS Trust and Health Board maintain that they are continuing to work closely in order to address handover delays and yet any improvements appear extremely limiting. Deaths are occurring and will continue to occur as a result of delayed ambulance attendances caused by these multifactorial issues.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 17 April 2023. 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 sent a copy of my report to the Mr Strachan's family and 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	20 February 2023 **SIGNED:** K Sutherland. Kate Sutherland, Assistant Coroner for North Wales (East & Central)