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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Local Health Board
1	**CORONER** I am Kate Sutherland, Assistant 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 11 January 2021 an investigation was commenced into the death of Carolyn Nancy Price (DOB 3/6/1958) who died on 1 January 2021. The investigation concluded at the end of the inquest on 25 April 2023. The conclusion of the inquest was a narrative conclusion as follows : Nancy Carolyn Price died on 1 January 2021 at Ysbyty Glan Clwyd. There was a delay in assessing her and transferring her from Ysbyty Maelor to Ysbyty Glan Clwyd to the extent that there were missed opportunities for her to undergo timely and possible life saving surgery.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows : Nancy Carolyn Price, aged 62 at the time of her death, presented to the Emergency Department of Wrexham Maelor Hospital on 30 December 2020 via ambulance which had arrived at her home at 16:37. She had sudden onset of movement and sensation in both lower limbs since midday. She was eventually seen by a medic, at approximately 9.45pm, when limb ischaemia was diagnosed. In consultation with the on call vascular consultant at Ysbyty Glan Clwyd, where vascular services are centralised for the Health Board, urgent CT angiogram was advised, IV heparin and pain relief, and also urgent ambulance transfer to Ysbyty Glan Clwyd. Nancy Price arrived many hours later, at approximately 3am and required rehydrating prior to the surgery. The surgery was commenced at approximately 05:55. Following surgery she developed multi organ failure and died on 1 January 2021.

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. – An investigation was commenced by the Health Board into the death of Nancy Carolyn Price, a significant time after her death and was completed only on 9 June 2022, some 17 months after her death. At Inquest it was identified that not all actions arising have been fully completed and the dates by when actions ought to have been completed (according to the investigation report) not adhered to. For example, the investigation report was due to be shared with vascular services to share learning by June 2022 (once approved) and yet the Report was only shared with vascular services in January 2023. The actions arising from the investigation report are not always realistic. For example, one action was to identify any gaps in knowledge with regards to assessment and management of vascular emergencies, including recording of limb colour, sensation and movement, by the end of June 2022, approximately 3-4 weeks after the final report. I have previously issued Prevention of Future Death Reports to the Health Board pertaining to the lack of timeliness of their investigations. I remain significantly concerned that the strategic management of internal Health Board investigations is lacking leading to investigations that are too slow, actions are not always realistic and, as a result, identification of areas for learning and training are not understood quickly enough, such that deaths will occur or will continue to occur into the future unless rapid action is taken.
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 21 June 2023. I, Kate Sutherland, 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 26 April 2023  Signature Assistant Coroner for North Wales (East and Central)