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 Health Board (BCUHB), Welsh Ambulance Service Trust (WAST), North Wales Local Authorities
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 30 December 2022 an investigation was commenced into the death of Jean Frickel (DOB 4/2/43) who died on 20 December 2022. The investigation concluded at the end of the inquest on 20 June 2023. The conclusion of the inquest was a narrative conclusion as follows:- Jean Frickel died on 20/12/22 at her home address from a naturally occurring disease process. The time it took for the ambulance to arrive meant that she was denied the opportunity for possible life extending treatment at hospital.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Jean Frickel had required an ambulance on 19 December 2022 due to symptoms of shortness of breath and confusion following a GP home visit. She was in reasonably poor health. A call was made by her husband to WAST at 17:09 hours. At 08.07 hours the following morning a further call was made informing WAST that Jean Frickel was unresponsive and not breathing. Paramedics arrived at 08:12 and confirmed that she had died. It took 13 hours and 3 minutes from the initial call for paramedics to arrive. Cardiology evidence indicated that had Mrs Frickel received timely medical treatment then her life may have been prolonged by several weeks.

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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 was evidence from WAST and BCUHB that improvements had been made internally within their organisations. It seems that patient flow i.e. those patients who are ready to be discharged from hospital but are unable to be discharged due to insufficiencies in social care means that ambulances are unable to offload patients into the Emergency Department which then causes the community delays as ambulances are not readily available. I have not been presented with any meaningful evidence on the involvement of Local Authorities in the considerations by WAST and BCUHB of lack of patient flow due to social care deficiencies. I have previously issued Prevention of Future Death Reports to BCUHB and WAST pertaining to the length of time it is taking for ambulances to arrive to patients (as well as handover at hospitals). I remain significantly concerned that delays are continuing and that deaths will continue to occur into the future. Specifically, I require responses to the following:- 1. Extent of working relationship between WAST, BCU and North Wales Local Authorities to address the above issues; and 2. Extent of progress between WAST, BCU and North Wales Local Authorities in addressing the above issues; and 3. Extent of Strategic plan of action / improvement plan to address the above issues.
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 16 August 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 have also sent a copy of this Report to Eluned Morgan, Health Minister, for her information. 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 21 June 2023  Signature Assistant Coroner for North Wales (East and Central)