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 29 June 2022 an investigation was commenced into the death of Leonard Charles Harmsworth (DOB 29/3/33) who died on 18 June 2022. The investigation concluded at the end of the inquest on 19 June 2023. The conclusion of the inquest was a narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Leonard Charles Harmsworth died on 18 June 2022 at Ysbyty Glan Clwyd from cardiac related issues contributed to by a fractured ankle and immobility due to a fall. He had been admitted on 7 June following a fall at home. He remained under conservative management before undergoing manipulation. He suffered a sudden deterioration following a manipulation of his ankle and died on 18 June 2022.
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. – Following the fall at home on 7th June 2022 WAST were contacted at 05:23. An ambulance arrived 17 hours 22 minutes later. On arrival at Ysbyty Glan Clwyd Leonard Harmsworth then waited in the ambulance for 12 hours 4 minutes before being handed over to nursing staff. Whilst the time it took for the ambulance to arrive to Mr Harmsworth's home and the time it took for Mr Harmsworth to be handed over to nursing staff at hospital did not cause or contribute to Mr Harmsworth's death, the delays experienced are significant. It is understood that the matter of ambulance delays is not solely a matter for WAST hence this report being sent to those organisations involved in its impact across the Health Board area (to include the provision of social care where patients are medical fit for discharge from hospitals but without adequate placements / care in the community). 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 and handover at hospitals. I remain significantly concerned that delays are continuing and that deaths will continue to occur into the future.
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 15 August 2023. I, Kate Sutherland, the Coroner, may extend the period. I would be prepared to accept a joint response from all organisations. 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 20 June 2023  Signature Assistant Coroner for North Wales (East and Central)