John Gittins
Senior 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 John Gittins, Senior 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 the 17th March 2022 an investigation was commenced into the death of Emlyn Victor Roberts (DOB 09/05/48) who died at his home on the 14th March 2022. The investigation concluded at the end of the inquest on 5th of July 2023. The conclusion of the inquest was that the death was due to natural causes, namely 1(a) Left Sided Intrathoracic Haemorrhage (b) Ruptured Dissecting Aneurysm of the Arch of the Aorta
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are that at 20.01 on the 13th of March 2022, the deceased called an ambulance complaining of a sudden onset of pain and trouble breathing. He made a further call at 00.20 but due to an absence of available resources, an ambulance was unable to attend for a further seven hours at 07.27 on the morning of the following day, when he was found deceased at his home. In total there was a delay of almost eleven and a half hours from the initial call for help.
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. – Whilst there was no direct evidence at the inquest to establish whether or not the outcome may have been different if Mr Roberts had received earlier medical care and attention, the delay in the attendance of the ambulance is significant and unacceptable.

	It is recognised that the reasons for such delay are multifactorial and both I and my Assistant Coroners have issued multiple previous reports for the prevention of future deaths expressing similar concerns. One of my earliest such reports expressing concern regarding ambulance response times, was in relation to a death in March 2013 and yet more than ten years later this problem has become significantly worse rather than better. 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 medically fit for discharge from hospitals but without adequate placements / care in the community). I remain significantly concerned not only that delays are continuing and that deaths will continue to occur into the future, but also that there is inadequate cohesive forward thinking or planning either in relation short term pressures (eg. winter pressures) or with a view to finding longer term solutions.
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 31st August 2023. I, John Gittins, 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 6th July 2023  Signature Senior Coroner for North Wales (East and Central)