Kate Robertson
Senior Coroner for North West Wales

	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 Robertson, HM Senior Coroner for North West Wales
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 19 January 2023 an investigation was commenced into the death of Mary Elizabeth Jones (DOB 30/12/36) who died on 14 January 2023. The investigation concluded at the end of the inquest on 7 July 2023. The conclusion of the inquest was that Mary Elizabeth Jones had died from natural causes contributed to by a fall.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- On Sunday 4th December 2022 at around 10am Mary Elizabeth Jones had an unwitnessed fall at home. An ambulance was called which arrived 26 hours and 23 minutes later. She was taken to Ysbyty Gwynedd. She remained on the back of the ambulance due to Emergency Department pressures for a further 8 hours and 23 minutes. She was assessed by a doctor on the back of the ambulance at around 8pm on 5th December. CT scan of her pelvis identified an undisplaced fracture. She deteriorated on 17 December 2022 with low blood pressure and abdominal tenderness and a new oxygen requirements and was receiving antibiotics for a suspected urinary tract infection. By early January 2023 a further deterioration was noted – she was drowsy and eating less and her blood tests showed a drop in haemaglobin. She had a blood and iron tranfusion. An abdominal bleed was diganosed on 6th Janaury and she had a poor prognosis. Palliative care was commenced and she sadly passed away on 14 January 2023 certified at 18:00 hours at Ysbyty Gwynedd.

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 – This is a further Report, of several by me, as both Senior Coroner for North West Wales and Assistant Coroner for North Wales East & Central relating to matters of ambulance delays and inability to offload patients in a timely manner into Emergency Departments across North Wales. Evidence was heard at the Inquest that the initial delays experienced by Mary Elizabeth Jones whilst awaiting an ambulance and waiting in the rear of the ambulance possibly contributed indirectly to her existing frailty. Whilst not in themselves causative of Mrs Jones' death it remains a significant concern that despite evidence of improvements by the Health Board and WAST upon which I have previously been provided, that even as recently as December 2022, unacceptably lengthy delays remain such as in the case of Mary Elizabeth Jones. I have still 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.
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 4 September 2023. I, Kate Robertson, the Coroner, may extend the period. I am willing to accept a joint response from all to whom this Report is made. 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 10 July 2023  Signature Kate Robertson HM Senior Coroner for North West Wales