David Pojur

Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Betsi Cadwaladr University Health Board (BCUHB) 2. Welsh Ambulance Service Trust (WAST)
1	**CORONER** I am David Pojur, 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 29.03.23 an investigation was commenced into the death of Philip Hawkins (DOB 09.07.1925) who died on 23.03.23. The investigation concluded at the end of the inquest on 18.07.23. The conclusion of the inquest was Accident.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- On 18.3.23 Mr Hawkins, aged 97, suffered a fall at home and was transferred by ambulance to hospital where he subsequently died.
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 – Entry into Hospital and Delay to bed allocation 1. Mr Hawkins arrived at hospital at 13:25 on 18.03.23 and remained in the ambulance until 23:42 when he was 'offloaded' onto a corridor in the Emergency Department (ED). 2. He was moved to a rapid assessment room in the ED at 11:33 on 19.03.23 and then into a cubicle at 21:47, the same day. 3. Mr Hawkins was eventually allocated to a bed from the ED, at 19:17 on 20.03.23. Care Concerns in the ED 4. On 18.03.2 at 02:49 there was no space for a nurse to attend to Mr Hawkins' personal care needs or assess his pressure areas. 5. On 19.03.23 at 12:18, Mr Hawkins needed 'repeat bloods' but this was never done nor highlighted to clinicians.

	6. On 19.03.23 at 00:31 Mr Hawkins was given oxygen but there are no nursing notes to indicate why or whether this was discussed with a clinician. 7. There is no written nursing documentation in relation to Mr Hawkins' care from 21:52 on 19.03.23. 8. Mr Hawkins was nil by mouth but this was not made known to visitors who fed him. Staffing 9. There were insufficient nursing and clinical staff to attend to the numbers of patients as outstanding nursing shifts went unfulfilled on the nursing rota. 10. Due to the presenting circumstances, staff were unable to fulfil their role in caring for Mr Hawkins. 11. Specifically, I am concerned as to the wait and delay Mr Hawkins had to endure to enter hospital and the same in respect of being provided with a bed; the inability of staff to tend to him; the lack of available staff and the lack of written record of assessment and treatment.
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 12.09.23. I, David Pojur, 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 18 July 2023  Signature Assistant Coroner for North Wales (East and Central)