REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **– Interim Chief Executive Betsi Cadwaladr University Health Board**
1	**CORONER** I am Sarah Riley, assistant coroner, for the coroner area of 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 09/06/2022 I commenced an investigation into the death of JAMES JONES. The investigation concluded at the end of the inquest on 30/08/2023. The conclusion of the inquest was: Medical Cause of death: 1a Cardiac arrest 1b Bowel ischaemia 1c Superior mesenteric artery occlusion 2 Ischaemic heart disease Conclusion: Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** When James Jones was transported to Ysbyty Gwynedd by ambulance on the 27th June 2021, he had a 4-6 day history of abdominal and chest pain with vomiting. He had not opened his bowels for a few days and had reduced urine output. Mr Jones arrived at Ysbyty Gwynedd at 21.33hrs on the 27th June 2021. He was admitted to the Emergency Department's Red Zone at 22.34hrs and was observed by nursing staff throughout the night. Mr Jones was first seen by a Doctor at 6.18am with the assessment recorded at 07.22am. X-rays were performed and at 7.43am, the suspicion of a small bowel obstruction was confirmed, with evidence of dilated small bowel loops on abdominal Xray. Mr Jones was then referred to the surgical senior house officer who reviewed the X-rays and agreed to further assessment. A decision to perform explorative surgery was made at 12.45pm and Mr Jones was taken to the anaesthetic room in preparation for surgery at 3.20pm. Between his arrival at the hospital and being taken to the anaesthetic room in preparation for explorative surgery, Mr Jones experienced the following delays: - Approximately 10 hours to be seen by a Doctor in the Emergency Department – He was triaged at 22.15hrs on the 27th June 2021 and assigned to triage category 2. The evidence was that the aim is for a Dr to see triage category 2 patients within 10 minutes but the wait for Mr Jones from the point of triage to seeing a Dr was 8.5 hours. - A further four hours for a scan to be performed and the results to be available. - A further 3 and a half hours before he was taken to the anaesthetic room.

	In total, Mr Jones waited 17.5 hours to be taken to the anaesthetic room. Mr Jones was intubated in preparation for surgery but suffered a cardiac arrest prior to administration of anaesthetic. The Consultant Colorectal Surgeon giving evidence at the inquest did not consider the delay to have contributed to the outcome in Mr Jones's case but was of the view that. continuing failure by Ysbyty Gwynedd to render care in a timely manner, as seen in Mr Jones's case, may lead to missed opportunities that may prove fatal for other patients.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Continued pressures within the Accident and Emergency department at Ysbyty Gwynedd will result in: (a) Doctors not having the capacity to review patients in line with the "aim" e.g within 10 minutes for triage category 2 patients. (b) Missed opportunities that may prove fatal (2) Current staffing levels being insufficient to meet demand and safely care for patients Although the delays did not cause or contribute to death in this case, I am concerned that if there are similar delays in similar life-threatening situations in future, deaths will occur.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 by 2nd November 2023. I, 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 Chief Coroner and to the following Interested Persons: The family of James Jones 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	**[DATE] 06/09/2023** **[SIGNED BY CORONER]**  **Assistant Coroner for North West Wales**