**John Adrian Gittins**
**Senior Coroner for North Wales (East and Central)**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW. |
| 1 | **CORONER**<br><br>I am John Adrian Gittins, Senior Coroner for North Wales (East and Central) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 15th of August 2023 I commenced an investigation into the death of Maureen Elizabeth Owens (DOB 28.2.43 DOD 9.12.22). The investigation concluded at the end of the inquest on the 20th of March 2024. The cause of death was recorded as being due to 1(a) Multiorgan Failure 1(b) Bilateral Femoral Thrombosis (operated) 1(c) Peripheral and Central Vascular Disease and the conclusion of the inquest was by way of a narrative in the following terms :<br><br>The death was due to natural causes, contributed to by operational delays as a result of which the deceased was not afforded the timely care and treatment which may have optimised the prospects of a full recovery |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 6th of December 2022, whilst a patient at the Maelor Hospital Wrexham, the deceased developed a condition which required urgent vascular surgery, however her transfer for this procedure was delayed and despite subsequent surgical intervention, she deteriorated post-operatively and died at Glan Clwyd Hospital on the 9th of December 2022. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed the following matter 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.<br><br>The **MATTER OF CONCERN** is as follows. –<br><br>An investigation by the Health Board indicated that the transport request for urgent transfer for vascular surgery should have been booked by the ward with the Adult Critical Care Service Cymru (ACCTS) and not WAST and evidence was received in the course of the inquest which suggests that there is inadequate knowledge of the use of ACCTS and its operation across the whole of the Health Board, including clinical site managers as well as clinicians and nursing staff. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th of May 2024 I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Family of the Deceased and to the Chief Coroner.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 2nd April 2024<br><br>  <br>Signature<br>Senior Coroner for North Wales (East and Central) |