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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Welsh Ambulance Services University NHS Trust** Ty Elwy, Unit 7 Ffordd Richard Davies, St Asaph Business Park, St Asaph, Denbighshire LL15 2NG
1	**CORONER** I am John Adrian 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 7th of June 2024 I commenced an investigation into the death of Shirley Ann Hughes (DOB 22.1.42 DOD 6.6.24). The investigation concluded at the end of the inquest on the 23rd of October 2024. The cause of death was recorded as being due to 1(a) Sepsis of Unknown Aetiology 2. Rhabdomyolysis, Diabetes Mellitus and Lymphoedema and the conclusion of the inquest was that the death was due to natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are that Mrs Hughes collapsed at her home on the 1st of June 2024 and that a 999 call was made to WAST at 17.13 at which time this was allocated an amber 2 response. Due to resource issues, no ambulance was able to attend at that time and at 04.13 the response was upgraded to amber 1, due to the amount of time Mrs Hughes had been awaiting a response. Despite this upgrade there were still no ambulances available to attend until 07.48 on the 2nd of June, as a result of which Mrs Hughes had spent more than fifteen hours lying on the floor before being treated and admitted to hospital.
5	**<u>CORONER'S CONCERNS</u>** 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. The **MATTER OF CONCERN** is as follows. – For many years, myself and other coroners have raised concerns regarding so called "ambulance delays" and I recognise that the challenges faced by WAST around the availability of resources are the result of multifactorial issues, however on every occasion when evidence is presented at inquests, I am reminded that calls are prioritised using the Medical Priority Dispatch System (MPDS) by which a code is generated and that this is then matched to a response priority to provide an indication as to the most appropriate resource to respond. At the inquest of Mrs Hughes, I was advised that MPDS was introduced in 2015 and at that time it was envisaged that an amber 1 priority call would be responded to in 20 minutes, however it

	was clearly the case that the multifactorial issues which prevail today were not envisaged at that time and that as a consequence this raises questions as to whether the MPDS system remains fit for purposes. As a result of this evidence, I am concerned that lives are being put at risk.
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 by 23rd of December 2024 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 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 28th October 2024  Signature Senior Coroner for North Wales (East and Central)